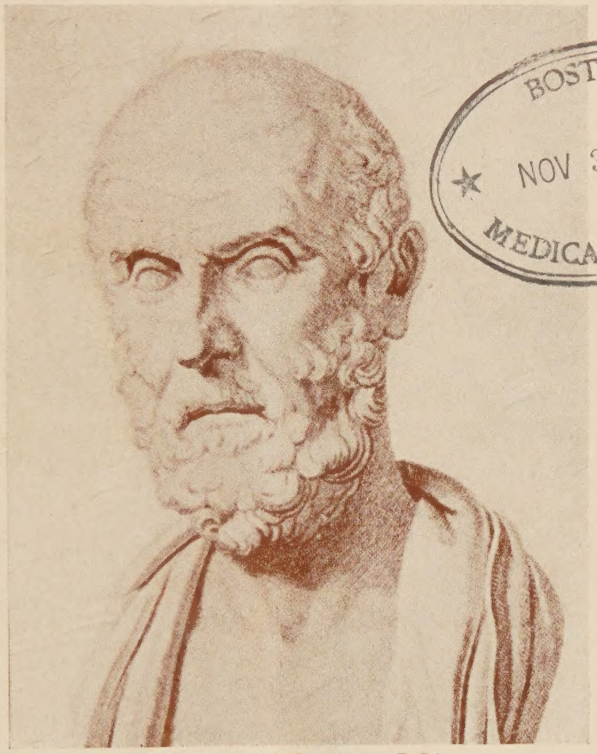
MEDICAL RECORD

83



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The Father of Medicine

Symposium on Neuropsychiatry, page 669

November 1944

Vol. 157, No. 11

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*GOTTLIEB, R. Whole Liver as an Adjuvant to Iron in the Treatment of Hypochromic Anemia, Canad. M.A.J. 47: 456-460 (Nov.) 1942.

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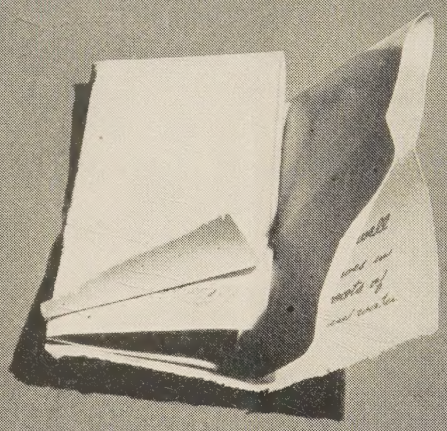

IN 1775 William Withering investigated a family recipe held by an old lady in the county of Shropshire, England, who "had sometimes made cures of cases of dropsy after the more regular practitioners had failed." How Dr. Withering gleaned from her the ancient family secret is not known but he found that while the concoction was composed of 20 or more different herbs the active ingredient was none other than the foxglove.

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NOVEMBER 1944

OPEN FORUM 646

EDITORIALS 679

PAPERS AND ADDRESSES

Ambulatory Treatment of Fractures of the Lower Limbs
Carlo Savini, New York, N.Y. 665

The Necessity for the Correction of Refractive Errors in Very Early Life
G. Griffin Lewis, New York, N.Y. 667

SYMPOSIUM ON NEUROPSYCHIATRY

The Aging Mind
I. L. Nascher, New York, N.Y. 669

Alcohol and the Social Tendencies of Men
Arthur L. Foxe, New York, N.Y. 671

Psychosomatic Obesity
Israel Bram, Philadelphia, Pa. 673

Pain Relief in Sciatica
Daniel C. Reyner, Atlantic City, N.J. 676

The Physician's Attitude Toward Prostitution and Juvenile Delinquency *(Abstract)*
A. L. Wolbarst, New York, N.Y. 677

NEWS ITEMS 681

BOOK REVIEWS 683

MEDICOLEGAL NOTES 684

MISCELLANY 686

VOL. 157, NO. 11
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THE PHYSIOLOGIC AID TO NORMAL EVACUATI

Dupuytren's Contracture

C. E. Corlette (*Med. Jour. Australia,* Aug. 19, 1944) says that while Dupuytren's contracture is not a common disease most physicians have seen an occasional case. The disease is said to have been described in England by Henry Cline and Sir Astley Cooper early in the nineteenth century, but it was brought effectively into notice in 1831 by Dupuytren, the French surgeon, and the disease has been known by his name ever since. The author states that Dupuytren's contracture is due to hypertrophy of the palmar aponeurosis, and a similar condition sometimes coexists in the foot. It is six and a half times more common in males than in females, and occurs most often in men over forty years of age, but sometimes in much younger people. In regard to the occupations of subjects of this disease, statistics collected by various writers, show that the number of nonmanual workers affected exceeded that of manual workers. This is an important finding, but is inconclusive, as it covers only a limited number of cases. It varies greatly in its rate of progress, in its grade, and in other minor features, but possesses a consistent general pattern.

There is a strongly marked tendency to heredity, but the heredity factor may sometimes be difficult to trace. In one family described, the disease leaped over two generations from great-grandfather to great-grandson. In another case it leaped a generation to pass to a grandson. Such cases make it practically impossible to exclude the factor of heredity merely because it has not been found. An attempt was made to find the proportion of familial cases to nonfamilial, or supposedly nonfamilial cases, in a whole known community of affected persons living at the time of investigation. Of these, twenty out of thirty-two had a known family history of the disorder and twelve had not. Other cases were not usable; three patients were rejected because they knew nothing, even of their parents. Fifteen more had a family history of the disorder. The total number of cases amounted to fifty.

The still current view that Dupuytren's contracture is due to trauma or toxemia is criticized. Such theories are found to depend on conjecture, a tacitly assumed major premise, without attempt at proof. The assumption is that the condition present is an ordinary chronic fibrositis, and that as such it can be caused by agencies such as trauma or toxemia. It is pointed out that if Dupuytren's contracture can be caused in this way, it provides an instance of the origination of a condition which is passed on to descendants, preserving its pattern. This presents a dilemma which is intolerable, and the theory is decisively rejected. The more likely alternative is that all cases of Dupuytren's contracture are familial, and would always be found so if the descent and complete family history were accurately known. It is suggested that the great preponderance of males, which extends to all cases, familial or supposedly nonfamilial, is capable of a Mendelian explanation.

Many forms of treatment have been used, but all have proved ineffectual, and adequate operation has been found to be the only means of controlling the disease. The treatment consists in early and radical extirpation of the fibrous structure in progressive cases, but not, as a rule, in static cases. In old contractures little improvement can be expected, and in advanced cases amputation may be advisable.

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Open Forum

Paralysis Protection

To the Editor

In the May issue of the MEDICAL RECORD, one of your contributors, Dr. Robert Marshall, in a paper entitled "A Physiological Paralysis Protection", ridicules my hypothesis of vitamin B deficiency as a basic factor in the etiology of poliomyelitis, and states that my papers on this subject are merely a revival of and an attempt to justify a similar theory advanced by Dr. Simon Baruch in 1916. He further casts reflection upon the veracity of my clinical observations on the effect of vitamin B therapy in poliomyelitis. These statements are made in spite of the fact that in a personal communication under date of September 19, 1942, I informed Dr. Marshall that at the time my first paper was written (Dec. 1937) I knew nothing of Baruch's reference to this subject. My attention was subsequently called to McCann's reference to Baruch's remarks. It should be needless to state, however, that at the time of Baruch's reference to a possible relationship between poliomyelitis and beriberi there was no correlated clinical data and little or no knowledge of the physiological action of vitamin B_1 upon which any plausible hypothesis of this nature could have been founded.

Subsequently, I also learned of a reference by Albert P. Mathews, in his work on *Biochemistry* (Wm. Wood and Co., 1936), regarding the very close similarity of the neuropathological changes in poliomyelitis and those produced by vitamin B deficiency. He suggested that the destructive changes in this disease may be brought about in an indirect way by the intracellular vitamin B-depleting effect of the infectious agent. He, however, unlike your contributor, did not feel slighted because I did not refer to his intimations in this respect. On the contrary, he lauded my work in a personal communication under date of April 12, 1938, as follows: "Thank you for writing me and sending me a copy of your paper, 'Poliomyelitis: Vitamin B Deficiency a Possible Factor in Susceptibility'. I have read it with the keenest pleasure and it is the best statement I have seen on this subject. You have said just what I had in mind when I wrote that brief paragraph in my *Principles of Biochemistry,* only you have added much new evidence which I did not know about. I believe you are right in every point you have made."

The fact that Baruch, Mathews and I, each independently, have regarded the clinical picture in poliomyelitis as suggestive of vitamin B deficiency is all the more evidence in support of my hypothesis.

For a more conclusive résumé of my deductions in this problem I would refer your contributor to my latest paper, under title of "The Pathological Affinities of Beriberi and Poliomyelitis", which appears in the July issue of the MEDICAL RECORD.

W. J. McCORMICK
Toronto, Canada

Ringworm

To the Editor.—

I wish to bring to the attention of all who are interested in the present epidemic of ringworm in New York City, my article published in the May 3, 1933, issue of the MEDICAL JOURNAL AND RECORD, entitled "Treatment of Ringworm by Pressure."

HEALTH

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George E. Barnes, M.D.
Herkimer, N.Y.

Health of Troops in the United States

Admissions to military hospitals from troops stationed in the United States show that these soldiers are much healthier than were the troops stationed here during the last war, according to a report issued by the office of the Surgeon General. During the mobilization period, admissions for disease increased somewhat over the peacetime rate, but this rate is now dropping to peacetime level and rates of admission for respiratory and all important communicable diseases are far lower than in 1917-1919. The death rate shows an even more marked improvement. It is not only lower than in World War I, but also lower than the rate for the intervening peace years. This is probably due largely to the following factors: (a) reduced incidence of several communicable diseases which contribute appreciably to the mortality rate; (b) improved methods of treatment, most important being the introduction of chemotherapeutic agents, and (c) lowered average age of troops. Among the communicable diseases figuring prominently in the present war are:

Meningococcal meningitis—As in the civilian population, this disease reached a prevalence several times higher than the normal interepidemic level in 1943 however, its prevalence has been somewhat lower than in the last war and its mortality, thanks to the sulfonamides, has been only a small fraction of that in the last war. The case fatality rate was 4.5 percent in 1943 against 34.3 percent in 1917-1919.

Primary atypical pneumonia—Comparison with previous periods is impossible as this disease has only recently been recognized clinically. There is evidence that more of the pneumonias now occurring are primary atypical than of known bacterial etiology. The case fatality rate has been low. The disease has had a seasonal distribution similar to that of the common respiratory diseases.

Diarrheal diseases—This group of diseases of diverse etiology, but having a common basis in deficiencies of sanitation, has shown a considerable increase from peacetime owing to the much greater number of troops on maneuvers, especially during the summer months with the added problems of field sanitation. Case fatality has been low. The present trend is downward.

With respect to other communicable diseases, the record has also been excellent. Measles, mumps, and scarlet fever are reduced greatly, while diseases against which immunizing methods are practiced (typhoid, smallpox, tetanus) have all but disappeared.

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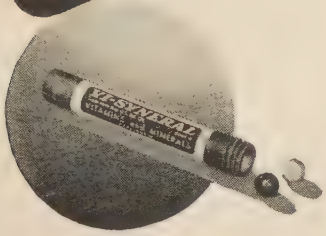

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Death Resulting From a Large Dose of Verona Not Considered "Accidental"

In an action on the double indemnity provision in l life policy instituted in the Federal District Court fo eastern Missouri, on appeal from a judgment for th defendant in a trial without a jury, three questions wer involved: 1, What is the meaning of the general ter "poison" in an insurance exclusion clause under Mis souri law; 2, whether it reasonably appeared that th trial court applied that meaning in finding that barbita or veronal "taken in quantity and under the circum stances and with the result shown in evidence was poison"; and 3, whether, even if the trial court failed t apply that meaning, the judgment still must be affirme on the basis of the further finding that "the death o the insured did not result from accidental means".

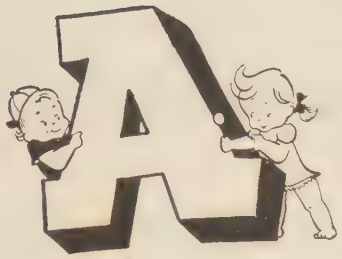
The insured had a chronic circulatory ailment in on of his legs, which at times caused him great pain, fo the relief of which he used barbital or veronal tablet At that time they were procurable at any drug sto without a medical prescription. One tablet is a norma dose. Insured commonly took one or two tablets at time. A few months before his death he took ten, wit out explanation, and was found in a coma in the bas ment of his home. After he had recovered from that a tack, his wife apparently separated from him and in stituted proceedings for divorce, and he changed th beneficiary of his life policy. He was a heavy drinke the evidence tending to show that he averaged "one t three quarts" of whiskey a day, and that he had ha marital trouble although this was denied by his widow

One day he expressed himself as in great pain an asked an acquaintance to obtain for him from a dru store two tubes of veronal, consisting of twenty t twenty-four tablets, and a bottle of empirin compoun He emptied the two tubes of veronal into his hand t gether with some of the empirin and "started out t take them" but "spilled quite a few". The hotel au thorities insisted that he go to a hospital, where he die three days later. The cause of his death was recorde as acute drug intoxication. The question the Circu Court of Appeals entertained for consideration wa Was the insured's death one from poison, under Mi souri law?

The court quoted from dictionaries and court opi ions as to the common meaning of a poison. Its sum ming up was that a poison "is a substance which ord narily has such a harmful or deadly chemical effe upon the body that it ought not to be taken internal without technical familiarity or medical direction There may, however, be substances as to which th specific concept may possibly vary somewhat with th conditions.

Whether the substance involved in the case is a po son may be a question of fact for the jury, but with th right to apply to the evidence such common knowled and experience as may exist with respect to the su stance. In the present case the question was held to properly one of fact and not of law. The testimony the experts conflicted as to whether barbital was or w not a poison. The trier of the fact was held to have th right to consider this testimony, together with all th other evidence and in the light of common knowled and experience, to determine whether general publ concept and popular understanding would regard th insured's death from barbital here as a death from po son. (Continued on page 66

The "ABC" of Vitamin D Therapy



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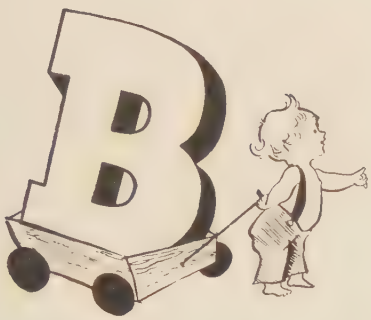

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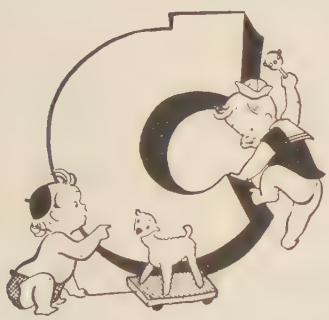

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*Musser, John H., Internal Medicine, Lea and Febiger, Philadelphia, 3rd Edition, 1938, page 1048.

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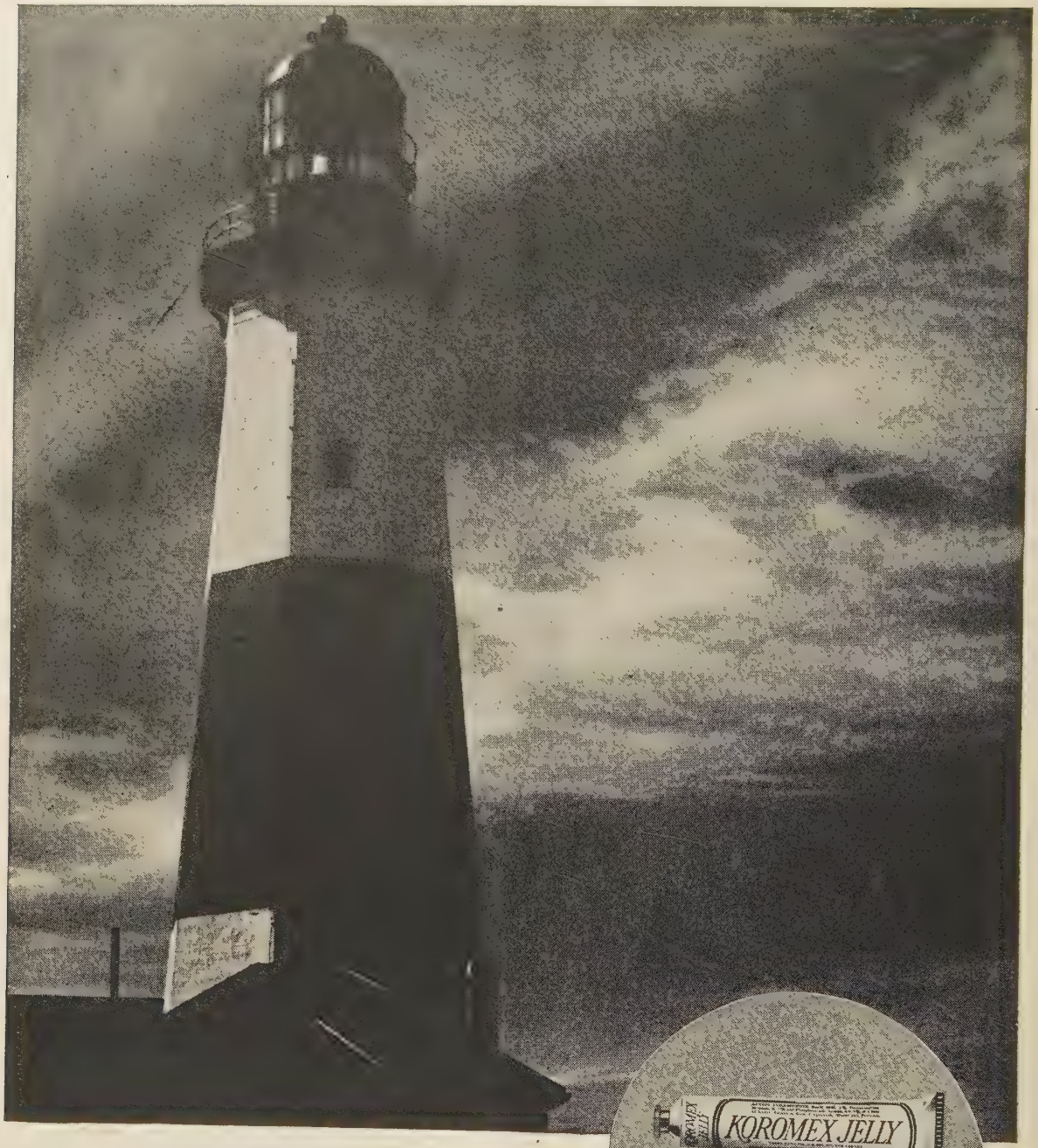

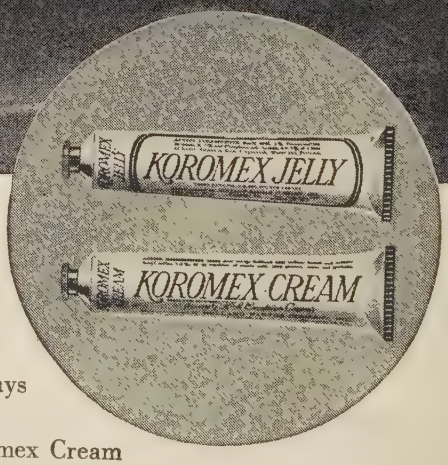

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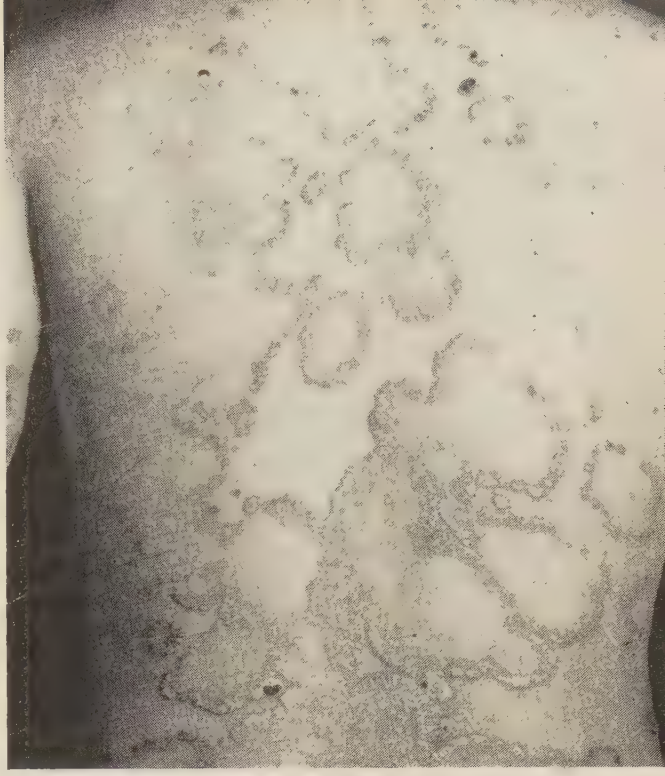

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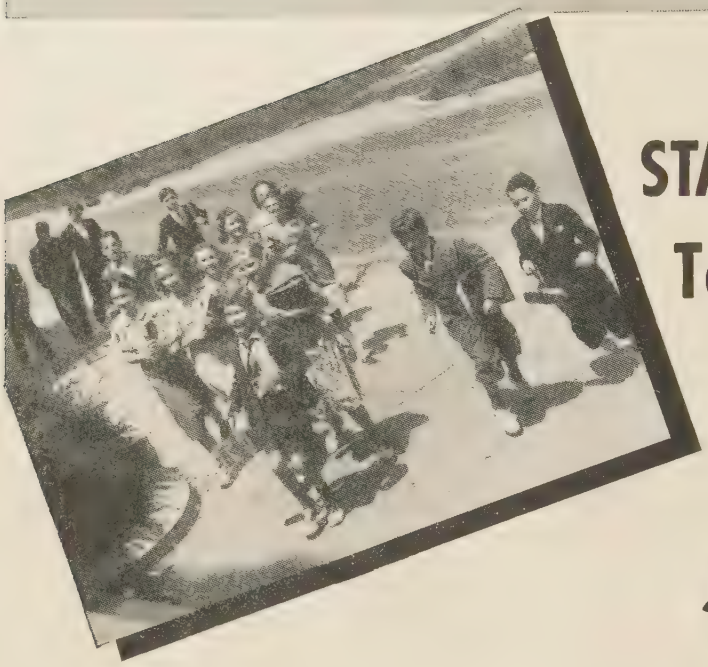

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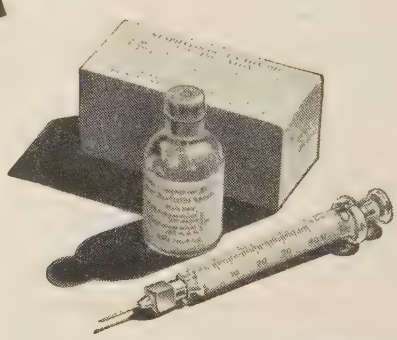

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*Etris, S., J. Immun. *46*:309 (May) 1943; Faust, F. B., and Etris, S., J. Immun. *46*:315 (May) 1943; Goodman, M. H., Arch. Derm. & Syph. *47*:640 (May) 1943; Jordan, C. B., Urol. & Cut. Rev. *47*:185 (March) 1943.

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The Circuit Court held it error to apply only a scientific or toxicological standard, and in failing to determine whether barbital or veronal was a poison by popular concept definition. Under the Missouri decisions, cited by the court: "In Missouri, therefore, death which is merely the unexpected result of a wholly unintentional act is not a death from accidental means. To constitute the means accidental in such a case, some causative mischance, slip, or mishap must have occurred in connection with the intentional act."

Under Coldwell vs. Travelers Ins. Co., 305 Mo. 619, 267 S.W. 907, 39 A. L. R. 56 (a surgical operation case), if the insured in the present case intended to take the number of veronal tablets that he did, even though he did not anticipate that death would result, his death would not be one from accidental means. "If the circumstances can be said to be such as reasonably to permit of an inference that by some mischance, slip or mishap he took a greater quantity than he intended or realized, then his death might properly be found to be one from accidental means. But whether he took the number of veronal tablets that he did, even though he did not anticipate that death would result, his death would not be one from accidental means. But whether the insured took the number of veronal tablets he intended, or whether some mischance, slip or mishap occurred so that he was not aware of the quantity he was taking, the question was at most one of inference and fact for the trial court. On the evidence we cannot say that the court's finding that the death here did not result from accidental means is clearly erroneous, and it accordingly must be permitted to stand."

Moore, J., concurred in part, on the ground that, regardless of the foreseen or unforeseen consequences of insured's act, the act itself does not fit the definition of "accidental means" applied by the Missouri courts. But on the question of "poison" he differed from the majority opinion as to the meaning of Dezett vs. Fidelity and Casualty Co., 176 Mo. 253, 75 S.W. 1102, where the insured had taken morphine by the advice of his physician, which case he thought controlling here. Veronal, he considered, was just a substance fitting the Dezett case rule, being "a substance commonly used for medicinal purposes, but having poisonous effect in certain dosage and under certain circumstances". Anbuchon vs. Metropolitan Life Ins. Co., Eighth Circuit Court of Appeals 142 F. 2d 20.

Program for Industrial Health

Dr. Leverett D. Bristol, chairman of the Health Advisory Council of the United States Chamber of Commerce, testified before the United States Senate Subcommittee on Wartime Health and Education, in Washington, D.C. on September 19th in regard to industrial health. He said that a national health survey showed that six million people in the United States, according to the National Health Survey, were absent from work because of illness each winter day and twenty-three million people were chronically ill, impaired or defective. While plant hygiene and medical supervision of the worker are essential, it is important to realize that about nine-tenths of worker illness comes from causes outside the plant. Therefore, industrial health means community and home health, and any industrial program is incomplete unless these are included. The "company surgeon" will no doubt be necessary, because of

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Reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

accidental injuries and compensation problems, but any industrial health program should include the more active direction of any such program by physicians well trained in health and preventive medicine. He pointed out that active measures should be taken to promote occupational health and the prevention of tuberculosis, syphilis and various types of emotional maladjustment and actual mental disease. In formulating the fundamental objectives of a coordinated program, Dr. Bristol pointed out that it was important to stimulate the evaluation of important hazards to health and safety and to make specific and practical recommendations for the elimination of any hazards encountered.

Provisions should be made for at least minimum medical services in all industries, including physical examinations, and a system of referral for the correction of physical defects to be worked out with the cooperation of the medical profession and community hospitals. To implement such a program he suggested that joint coordinating commissions and boards should be set up to include one representative from each of the following groups: employees, organized labor, industrial management, Chamber of Commerce, medical and dental societies, nursing and hospital associations, the Health Department, Safety Council, and educational institutions.

Tetanus Immunization

Tetanus has been virtually eliminated from our armed forces as a result of compulsory immunization, according to an announcement by Major General Norman T. Kirk, Surgeon General of the U.S. Army, who says that not a single case has been reported among completely vaccinated troops and there has been only a handful of cases throughout the entire army. These occurred prior to vaccination or before the immunization process had been completed. The Navy, which also requires tetanus immunization process, has had no cases of the disease among sailors or marines wounded in combat up to September 15, 1944, according to the Navy Bureau of Medicine and Surgery. The most recent account illustrating the value of tetanus immunization was given in the report of a navy medical officer who served aboard a hospital ship on which two hundred and eighty-four Japanese and three hundred and eighty-four Americans, all wounded in the same engagement, were being treated. Fourteen cases of tetanus, ten of which were fatal, occurred among the Japanese. None of the Americans developed the disease. Army medical records indicate that the Japanese do not immunize actively against tetanus.

Our Contributors

I. L. Nascher, Ph.G., M.D., New York, pioneer in the field of geriatrics, retired from active practice in 1934. He was graduated from the New York College of Pharmacy (now a part of Columbia University) in 1882 and from the medical department of New York University in 1885. He has served as chief physician of the Department of Hospitals and the Department of Welfare, was acting superintendent of Gouverneur and Harlem Hospitals, and night superintendent and alienist at Kings County Hospital. During his association with these two departments, he did interesting rehabilitation work among the inmates of the state institutions under his charge, restoring many by giving them an incentive to work through token pay and arousing their self-respect. Many of the methods he introduced are still in use. He has visited many foreign countries, including Russia, where he had an excellent opportunity to study the hospital situation in that country. He has always taken an active interest in the care of the aged and was first to suggest the term "geriatrics" for the field of medicine which deals with senescence. He has truly been called the "father of geriatrics".

* * *

Israel Bram, M.D., Philadelphia, Pa., has devoted nearly thirty years exclusively to clinical research on goiter and endocrinology. He is the author of four books on goiter and the thyroid and has contributed over one hundred and fifty articles to medical journals on disorders of the ductless glands. Dr. Bram has taught at the Medico-Chirurgical College, and more recently at the Jefferson Medical College. His hobbies are Shakespeare, philosophy and the musical classics.

* * *

Arthur N. Foxe, M.D., New York, N.Y., was graduated from Jefferson Medical College, Philadelphia, in 1927. He was formerly physician to Bellevue Hospital; instructor in neurology at Bellevue Medical College; physician to Saint Lawrence State Hospital, and psychiatrist to the New York State Department of Correction. He now devotes his private practice to psychiatry. He has contributed numerous articles to the literature of his specialty and has published two books, *Crime and Sexual Development,* and *The Life and Death Instincts*. His hobbies are literature and painting in oils.

* * *

Carlo Savini, M.D., New York, N.Y., was graduated from the Faculty of Medicine and Surgery of the University of Rome, Italy, in 1887. For the past twelve years he has been visiting surgeon to the Columbus Hospital in New York.

* * *

Daniel C. Reyner, M.D., Atlantic City, N.J., was graduated from the University of North Carolina with a B.S. degree in medicine in 1916, and from the University of Pennsylvania with the degree of M.D. in 1918. He served with the United States Navy Medical Corps from 1918 to 1925, and since that time has practiced medicine in Atlantic City. He is a member of the staff of the Atlantic City Hospital, and chief of the department of neurology of the Municipal Hospital. He is a member of various national, state, and county societies, serving at times in an official capacity. His hobbies are golf, and philately.

* * *

G. Griffin Lewis, M.D., F.A.C.S., New York, N.Y., was graduated from Albany Medical College in 1890 after which he did postgraduate work for a year and a half at the University of Berlin, in Paris, and in New York. After finishing his special studies he practiced in Amsterdam, N.Y., until 1895. He then went to Syracuse, where he practiced his specialty of ophthalmology. He retired from practice in April 1939 and since that time has devoted himself to writing. He is the author of five books, two of which are on topics relating to his specialty, two on the subject of oriental rugs, and one entitled *The Book of Roses*. His hobbies are oriental rugs and roses.

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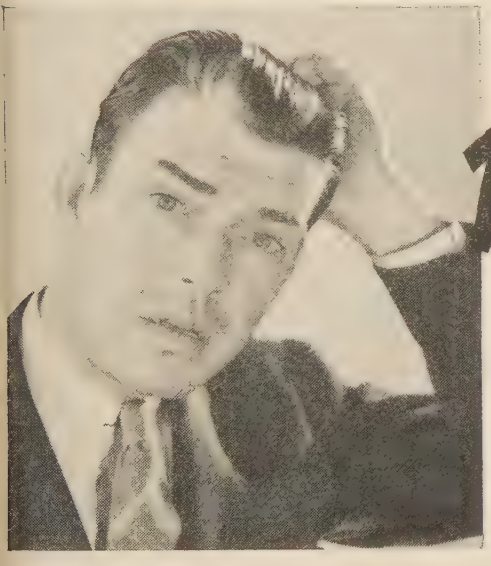

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[1] Diseases of the Skin: Sutton & Sutton, 1939, p. 99

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AMBULATORY TREATMENT OF FRACTURES OF THE LOWER LIMBS

Advantages and Limitations

CARLO SAVINI
New York, N.Y.

Since the time of Hippocrates it has been considered a self-evident truth that in the treatment of fractures it is necessary to keep the fragments immobilized in good apposition, in order to have a good callus formation. In the past, in all fractures of the lower limbs it was also considered necessary to keep the patient immobile in bed for the duration of the treatment.

Some surgeons, however, have for a long time challenged this old method and thought it was possible to treat many fractures of the lower limbs by immobilizing the fragments and allowing the patient to move around and walk. Of course, this ambulatory treatment cannot be applied to all fractures of the lower limbs. Some of these fractures may be very serious, some may be comminuted and with displaced fragments, and some may require open reduction and other operations. In the treatment of these fractures it is absolutely necessary that the patient stay quiet and immobile in bed until a good callus is formed. But not all fractures are so serious as that and in many cases it is possible to obtain a perfect immobilization of the affected limb without confining the patient to bed.

The results obtained by treating many simple fractures with massage and partial limited methodic mobilization of the fragments, and the ambulatory treatment of some fractures of the bones of the lower extremities, have proved that there is no foundation for the fear that it would be dangerous for all patients with fractures to move and to leave the bed soon after reduction. Moreover, it was found that remaining in bed for prolonged periods and the immobilization of the whole body for a long time were dangerous to the patient's health, especially of old people, and that leaving the bed as soon as possible prevented embolism, pneumonia, decubitus, constipation, difficulty of urination and general debility.

Limiting ourselves to the discussion of the treatment of simple fractures of the lower limbs, we note that as far back as 1831 Auguste Berard recommended that some patients with simple fractures of the leg should be treated out of bed and allowed to walk. The treatment recommended by Berard was adopted by many other surgeons, and later it was also suggested that not only patients with fractures of bones of the leg, but also some with fractures of the neck of the femur, could also be treated as ambulatory cases. Many different kinds of apparatus have been recommended to permit early mobilization of patients so affected.

Ambulatory treatment does not bring a more rapid healing of the fractured bone. The repair of any fracture is a slow natural process and it is not known if it is possible or even wise to accelerate it. Naturally, then, it cannot be expected that on account of this treatment the formation and calcification of callus, and the complete consolidation of the fracture can be attained more rapidly than with other methods of treatment. The main positive advantage is that with this treatment the patient is kept in a better general condition so that in a relatively short time he could be found so improved that any further care he may need could, without danger, be rendered to him away from the hospital.

Although the ambulatory method cannot be adopted for all fractures, but for only a certain number of cases, its advantages are so many that they should induce all surgeons to use it more frequently when reasonably possible.

It is not only on account of the lesion of the bone but also because of the debility of the muscular and nervous systems resulting from being kept inactive a long time in bed that patients with fractures of the lower limbs generally require from three to six months before they can carry on their work.

If the ambulatory treatment is adopted in the weeks of hospital treatment, patients learn to walk with crutches, to go up and down stairs and to take care of and help themselves so that while the immobilization of the affected limb insures the formation of a good callus, all the functions of the body are practically normal. When discharged, although patients are not yet completely able to do their usual work, they do not require continuous supervision. They need only the care that any convalescent does. Such care could be received in the out-patient department of the hospital.

Fractures reduced manually and without any operation give better results with this treatment, but at the present time manual reduction does not seem to be generally popular, and, as a consequence, the ambulatory treatment of fractures is not used as frequently as it should be.

It is a fact that there is probably no other surgical procedure that in the past has been so often considered unsatisfactoy, and so often criticized, as the manual

reduction of simple fractures in general and especially of fractures of the bones of the lower limbs.

About forty years ago such criticism was justified because then x rays were not widely used in diagnosis, and most surgeons relied exclusively on the perfection of their sense of touch in the diagnosis and reduction of fractures (1). But since radiological observation is now considered indispensable by every surgeon before and after reduction of any fracture, such criticism is no longer warranted. However, it seems that when a surgical procedure has a bad reputation, the same thing happens to it as to a man with a bad name: he is not trusted even though he reforms and leads a good life. For this reason, there still persists in the minds of some surgeons a feeling of diffidence in treating some simple fractures with manual reduction.

Manual reduction, as it is used now under the guidance and control of x rays, is sufficient for a great number of simple fractures. If we except fractures of the diaphysis of the femur, or multiple and comminuted fractures, there are few simple fractures of the lower limbs that necessitate a long period in bed or some operative procedures to maintain the fragments in place and insure a good union. Such operative procedures are internal fixation of fragments with metallic sutures, with plates or with nails. I would include in the operations the skeletal traction of the lower fragment with Steinmann pins, and the use of the Stader reduction and fixation splint.

Every one of these operative procedures has its indication and sometimes one is indispensable, but none of them should always be used as a standardized method for all fractures. They should be used only when the simpler manual method does not succeed, and should be performed only when absolutely necessary.

The surgeon must be ready to treat with operation fractures that require it. It would be just as wrong to insist on not operating when the operation is clearly indicated as to operate on fractures that could be treated more simply with manual reduction.

Naturally after an operation the patient can rarely be treated out of bed. Other fractures may not require an operation, but the general condition of the patient may be so serious that also for them the ambulatory treatment is out of the question.

In treating fractures, the surgeon must be guided in each case by that common sense derived only from personal experience and from the observation of each individual case, and not alone by theoretical science, routine or preconceived ideas. He must realize that there is no standardized treatment for fractures.

We can say that, on the average, more than one half of the patients with simple fractures of the bones of the lower limbs admitted to the hospital could be treated out of bed to their great advantage.

The secret of success in treating fractures manually is always to reduce the fracture immediately after the accident, or as soon after as possible. The reduction of a fracture should be considered a definite emergency operation, and the fracture reduced under anesthesia as soon as the patient is admitted to the hospital.

Of great importance is the choice of the apparatus to be used to keep the fragments in place. Complicated apparatus which, when applied, requires that the patient be confined to bed, should be limited to few cases, and not used in all fractures. When it is necessary to use them, such appliances should be removed when reasonably possible, as soon as the radiological examination shows a good reduction, and more simple one substituted that will permit the patient to leave the bed.

We must never forget that the main purpose in the treatment of fractures of the lower limbs is to make the patient able to walk, or in other words, to obtain a good function. For this it is most important that the general condition of the patient be good, and it stands to reason that a patient who is allowed some exercise out of bed every day will be in a better general condition than the one who has been kept immobile in bed for a long time.

For the success of the treatment, it is imperative to have the cooperation of the patient and of the personnel of the hospital, but sometimes these people do not share the doctor's opinion.

Among those who are admitted as free patients in the hospital, unfortunately some are ignorant and afraid to make any movement at all. They do not look with favor upon a treatment that they cannot understand. They do not believe that leaving the bed sooner will shorten their stay in the hospital.

Liability patients usually are desirous of having their injury considered more serious than it really is. They object to being treated out of bed for fear that it might appear that they had not been seriously hurt, and this might preclude a favorable verdict in court.

In the beginning, all these patients may be uncooperative, but with patience and tact, they can soon be made to understand the benefits of the treatment. When convinced, they cooperate with the surgeon and are satisfied and grateful.

It is only natural that some of the personnel of the hospital will not approve of patients hopping around on their crutches, disturbing the discipline of the service, and the peace and order so necessary in a ward. As a consequence, it is to be expected that they too will fight against the adoption of the ambulatory procedures. The cooperation of nurses is so important that the surgeon should try to lessen any inconvenience to them as much as possible.

The treatment consists essentially in keeping the fractured limb so protected that when the patient is out of bed the fragments will not be displaced. This can be done in various ways, according to the experience of the surgeon, but naturally the most simple way is the best. To me it seems that a light plaster of Paris bandage is the most practical means of immobilization, and if a splint is necessary, the most simple splint is the most satisfactory. But any apparatus that is not too heavy and that permits the patient to leave the bed without pain is good. The surgeon must do his best to make the patients leave the bed as soon as possible, and he will be surprised to see how quickly they learn to walk without any instruction or encouragement.

Summary

I have summarized in four statements the rules that, according to my opinion, should be followed in the ambulatory treatment of simple fractures of the lower limbs:

1. Fractures should always be reduced as soon after the accident as possible, and, if possible, before any swelling occurs in the limb.

2. Soon after reduction, a light plaster of Paris bandage should be applied with a little padding around the ankle and the knee.

3. Patients should be advised (but not forced) to leave the bed after reduction, or as soon thereafter as possible.

4. Patients should not try to walk until they feel able and desire to do so.

Reference

1. Beck, C.: Malunion of bones, *J.A.M.A.*, April 18, 1908.

43 West Eleventh Street.

THE NECESSITY FOR THE CORRECTION OF REFRACTIVE ERRORS IN VERY EARLY LIFE

G. GRIFFIN LEWIS
New York, N.Y.

In this generation when the efforts of the medical profession are directed towards preventive medicine, it seems as if the subject which I have chosen for this paper would be of sufficient importance to arouse the interest of every conscientious physician as well as of those who are in any way connected with our educational institutions or child welfare.

From a physiological, as well as a mental and moral viewpoint, the early years of school life are the most important in the individual's existence, because at this time the tissues of the eye are so pliable and yielding that they are easily modified for good or evil by circumstances and environment.

Furthermore, at this period the receptive faculties of the brain are in their highest state of activity. Impressions are then recorded and stored up which are never so clearly acquired in later years, so that if at this time the vision is seriously impaired, the whole system of education is practically stopped.

With each generation there is an increased demand upon the eyes for close work. The kindergarten requires their use at a more tender age, amusements are furnished which demand more accurate vision, and the more general use of artificial illumination lengthens the hours during which the eyes are employed for close work.

At birth and during the first few years of life practically all children are farsighted, but, under normal conditions, this farsightedness gradually decreases with the development of the eye. If, however, there is remaining enough farsightedness at the beginning of school life to demand excessive action on the part of the accommodative muscles, eyestrain is sure to result.

It is astounding how many children begin their school life with defective eyes. Statistics reveal that twenty-five percent of these children in the United States have visual defects and other symptoms of eyestrain. Doubtless fifty percent more have latent troubles due to a low degree of farsightedness or astigmatism, of which they are unaware but which sooner or later manifest themselves, possibly after much irreparable damage has resulted.

Myopia

While those with comparatively normal eyes and those whose refractive errors have been corrected by proper glasses maintain a nearly uniform percentage in all grades of school life, there has been a steady decrease in the percentage of farsightedness and a steady increase in the percentage of nearsightedness with the advancement to higher grades, being 3.3 percent in the primary grade and 31.4 percent in the freshman year of college.

This proves beyond question that nearsightedness results from the strain caused by farsightedness and astigmatism, unnecessarily brought about by the neglect to have refractive errors corrected before the beginning of school life.

Nearsight is a condition which, as a rule, causes little eye strain and therefore nearsighted children seldom complain and are often allowed to go without correcting lenses as a consequence of which progressive myopia ensues, resulting in many cases in choroiditis or retinal detachment and finally in industrial blindness.

Cross Eyes

Cross eyes are, in the great majority of instances, the result of refractive errors and specially is this true when there is a great difference in the refraction of the two eyes. As a rule squint is first noticed when the child is troubled with teething, indigestion or some other ailment but as the internal recti muscles gain in strength and the power of control lessens, the squint becomes more frequent and pronounced until parallelism of the eyes is totally and often permanently lost. The acts of accommodation and convergence are so intimately connected one with the other, that one cannot accommodate without converging or converge without accommodating. In the normal eye these two functions are instinctively maintained for the same point.

A farsighted child, in looking at near objects must necessarily exert his power of accommodation to a greater extent than does the child without hypermetropia. With this increased effort of accommodation is the increased stimulus to converge and permanent strabismus is sooner or later maintained by the constant innervation to converge, the eye with the higher degree of hypermetropia usually being the one which turns in.

When squint once becomes established, the child, in order to avoid the confusion of double images, soon learns to suppress the image on the retina of the diverting eye which, from disuse, gradually loses to a great extent its visual acuity. The younger the child is when the squint develops, the more rapid and complete is the loss of vision. Parents usually feel keenly such disfigurement in their offspring, but, through lack of knowledge and often by medical advice, they make the great mistake of allowing the child to go until it is too late to repair.

The function of fixation in these cases may be restored and the vision preserved by bringing the eye into use. This can be accomplished in the majority of cases without operative procedure by the adjustment of proper glasses under a cycloplegic. Glasses increase the distinctness of the retinal images, thereby stimulating the fixation power. They also relieve the ciliary strain and thus lessen the tendency to converge. Often the eyes are brought into parallelism almost instantly by correcting lenses.

The treatment of these cases should begin in the periodic stage, no matter how young the child is, for in its incipiency only can squint be cured and binocular vision maintained.

School Test

Thus far the only visual test which has been made of our school children's eyes, is with the test card by the teachers or school nurses. This card is a valuable subjective test, but to the layman it reveals only cases of defective vision.

If a child cannot see the letters at the required distance one can say, with reasonable accuracy, that he has defective vision, but if he does see the letters at the required distance, either his refraction is normal or he is accommodating sufficiently to overcome all defects, therefore, slight degrees of farsightedness or astigmatism can seldom be detected by this method.

Such cases are the most urgent as they are the ones who suffer from spasm of accommodation and eyestrain, and an excessive use of the eyes under these conditions will sooner or later result in some pathological change in the tissues of the eye that may or may not be permanent.

I am sure every oculist will agree with me that the most serious mistake in child hygiene, which has been made in the past and is constantly being made at the present time, is the fitting of glasses by men of mercantile life who know little or nothing of the anatomy, physiology and chemistry of the eyes or of the relationship of that organ to other parts of the body and whose business and profit depending, as it does, upon the sale of spectacles, results in their prescribing indiscriminately for all who consult them.

Cases of spasm of accommodation or apparent nearsight cannot be detected from those with real nearsight by one who is not familiar with the use of the ophthalmoscope and is prevented by law from using atropine, consequently those who are farsighted or astigmatic are frequently given nearsight lenses and those who are nearsighted frequently get lenses which are too strong and only tend to increase the optical defect. The attempt to adjust glasses when the muscle of accommodation is in action is just as absurd as to attempt to repair a watch while it is running.

From the foregoing facts it is evident that we have, in a large percentage of our children, a fruitful source of permanent visual impairment in the refractive and muscular anomalies of the eyes and that it behooves every conscientious physician to make sure that every child under his care undergoes a thoroughly scientific refractive examination under a cycloplegic, thus eliminating the existence of physical defects in these unfortunate children, placing them in a position of reasonable equity with their healthy companions and earning their everlasting gratitude.

Thousands of children already owe their emancipation from serious eye disorders to the ocular examinations made in schools and it is to be hoped that this paper may be instrumental in arousing greater interest in a subject of such vital importance to society and that it may stimulate greater effort to further the cause of eye care. By doing your part you will aid nature in relieving a great deal of suffering and rendering an immense amount of good, not only to the present, but to future generations.

1126 WALTON AVENUE.

Fracture-Dislocation of the Ankle

Theodore James (*Brit. Med. Jour.*, Sept. 16, 1944) says that before the war fracture-dislocations of the ankle were comparatively rare injuries, but have become more common as a result of flying accidents in the Service. The author describes a typical fracture-dislocation of the ankle which occurs in such an accident. The fracture line is irregular and extends obliquely through the ankle, and the fragments are widely separated. The injury is not compound. These accidents usually occur when a pilot is forced to make a crash landing. An x ray examination is necessary for a definite diagnosis, but with a history of the injury, a provisional diagnosis of fracture-dislocation may be made. Treatment is urgent, as in injuries of this kind, the blood supply to the body is cut off and a vascular necrosis takes place. Reduction is difficult, but if it is attempted should be open, with the foot put in a plaster cast for at least four weeks. The sutures are then removed and the plaster continued for about sixteen weeks. Partial talectomy is not advised. As backward displacement of the foot is prevented and any dorsiflexion permitted is limited. There is also painful friction between the anterior margin of the lower articular surface of the tibia and the fractured head of the talus. Arthritic pains develop and become worse with time. Shortening of the limb for about three quarters of an inch, with stiffness, produces a marked limp. Comparatively satisfactory results with talectomy may be obtained if the operation is performed with care and attention to detail, but when badly performed the results are irreparable. Where expert operative technique is available, arthrodesis is the treatment of choice. It is the surest way to stabilize the foot and to prevent an ever-increasing disability. It also obviates notable shortening of the limb.

External Use of Sulfonamide Therapy

Stephan Epstein (*Urol. and Cutan. Rev.* Aug., 1944) says that medications containing sulfonamides are without doubt of value in dermatological conditions but emphasizes the danger of sensitization. He presents six suggestions which may help to reduce the risk of external sulfonamide therapy. These are:

1. Sulfonamide ointments, lotions, and powders should be used only with proper indications. 2. Physicians should become aware of the special danger of sensitization in infectious eczematoid dermatitis. 3. Sulfanilamide should be substituted for sulfathiazole. 4. The patient should be informed that he has become sensitive to a sulfonamide. 5. Penicillin should be used in sulfonamide sensitive patients. 6. The public should be enlightened about the risks connected with the use of sulfonamides.

Symposium on Neuropsychiatry

THE AGING MIND*

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Of the many physiological changes occurring during the period of senile involution, the aging mind presents the greatest vagaries. I have for many years noted the mental changes in myself, now well past eighty, and in my wife whose mental impairment was first noticed at the age of seventy-six and who developed senile dementia, which at the time of her death three years later had reached the state of amentia. These two cases represent extremes in the changes in mentality in advanced age. Between them are many deviations from and variations in what we consider normal mental functions.

Usually the first sign of mental impairment noted is impaired memory, forgetfulness of names and haziness of events and their sequences. However, much earlier signs of mental impairment, though seldom noticed, are a general slowing down of all mental processes and rapid brain fag. The person speaks more slowly, reads more slowly and dictates more slowly. In conversation he is more deliberate in his replies, even hesitant where formally he may have been a master in repartee and argument. He must make a conscious effort to recall events and circumstances and fit them into problems of the immediate present. Another frequent sign of mental impairment occurring before the almost universal sign of impaired memory is lessened attention, while prolonged or intense attention brings on rapid brain fag. The elderly man who falls asleep in church or at the theatre was not inattentive but excessively attentive, and this brought on mental fatigue. I have seen men fall asleep during an exciting baseball game, a football game, even at a prize fight. The secretary of a lawyer, now in his late fifties, says her employer dictates more slowly than formerly and after a lengthy legal document or brief he takes a nap for a few minutes, yet rarely consults a law book for the exact wording of a law or decision. The late Abraham Jacobi wrote the introduction to my book when he was well along in his seventies. It was written on a score of little scraps of paper, each representing his work on one day. He told me he stopped the moment mental confusion or brain fag set in, even in the middle of a sentence or word. He referred to thirty-six authors who had written on old age conditions, giving many dates of publication, yet wrote most of the introduction to my book in his Adirondack camp where he had no access to his library.

The layman frequently speaks of the wonderful memory of some old person who recalls events of his early life, but a study of the mentality of such a person would show that he cannot recall recent events. This is not due to impaired memory but to lessened attention and weakened visual and auditory impressions, due probably to anatomical changes. The lessened attention may be nature's provision to prevent mental exhaustion, the same as we find in old persons who fall asleep during an interesting sermon or play. I know this from personal experience and frequent observation. This is akin to the physical fatigue following excessive physical strain, which if continued ends in exhaustion. Among the vagaries of the aging mind are obsessions, delusions, morbid fears, and tenacious retention of antiquated ideas, customs, styles, etc. We sometimes find old persons who discard old ideas about dress and appearance and make an effort to appear youthful, and we are wont to criticize and ridicule them. They should be commended and encouraged in their efforts to retain the spirit and appearance of youth. This tendency among the middle-aged to adopt modern, practical styles is growing, and even old persons are beginning to show a more lenient attitude toward the wearers of slacks, short skirts, and ankle length socks.

Until recently an ancient dame still rode in her coach with team and coachman, wearing an old fashioned poke bonnet and on gala occasions a much flowered hat, and petticoats which showed lace edgings when she stepped into her carriage. She abhorred electrical devices and used candles and gas light in her home.

Paranoiac delusions are rare in aging and old persons, but I have met a number of persons who, exaggerating some event of their lives, repeated the exaggeration so often that they firmly believed it was true. Occasionally the whole supposed event was an invention. A physician in this city made a large donation to a local Grand Army Post and was elected honorary member. He had previously visited Gettysburg with some of the post members, had studied the battle, especially the movements of a certain regiment in that battle, and selected the spot where he imagined he would have stood if he had been there. He frequently spoke of his part in the battle and in time this became a fixed delusion. There was no documentary evidence that he was in the war but he satisfied members of his post that he was a *bona-fide* veteran, yet there was ample evidence that he was never out of the city during the war period.

Aged persons frequently speak regretfully or boastfully of their former social or financial position, their former wealth or great business losses, or some remarkable achievement. There is often a grain of truth in their exaggerations which they finally believe themselves. The stub of a ticket to an opera performance, the only one a speaker ever attended, was frequently exhibited as an evidence that he was a confirmed opera goer, but he acknowledged that his memory was bad and he could not remember the name of any except the one he attended. A poor refugee boasts that he was a millionaire in Germany immediately after the last war, when a million marks were worth the fraction of a cent, and is discouraged because he is not shown the deference shown to millionaires in Germany before the war.

*Read before the second annual meeting of the American Geriatrics Society, Hotel Commodore, held in New York, June 9, 1944.

An early indication of the mental changes in the process of aging is inability to adopt and adapt oneself to new concepts of modesty and morality. The short skirt, introduced as a war necessity during the first world war, was viewed with horror by the middle-aged woman who was brought up to believe that a dress that did not cover the ankles was immodest. So, too, the aging mind cannot readily adapt itself to changing concepts of morality, birth control, unconventional social relations, deviations from the golden rule and the ten commandments, which are generally accepted as necessary under modern conditions of life.

The most bizarre of the vagaries of the aging mind occur in the realm of imagination. The novelist employs his imagination deliberately to create the pen pictures of the supposed events he describes. In the aging mind such pictures arise unbidden and often with all the vividness of reality. The individual knows that they are figments of the imagination and tries to dispel them by interposing real, serious problems or resorting to other mental diversions. Aging persons do not like to speak of what they can recognize as silly notions, and only tactful questioning will elicit this silly notion, day dream or whatever the individual chooses to call his unwelcome thought. However, if it is a pleasant picture that he has created he will consciously elaborate it, and may act upon it even though knowing that it is only fantasy.

Here are typical examples. An elderly man read in a paper the question, "What would you do if you suddenly became a millionaire?" He dismissed the question as an impossibility in his case. However, two days later, while sitting in his rocker, he suddenly thought of himself as a millionaire, worked out in his mind a plan to dispose of the million and actually wrote out checks covering that amount. He knew that he was a millionaire only in his imagination and having written the checks he tore them up.

A man after making his will went home, had a good lunch and afterwards, while smoking a cigar, imagined that he had been transplanted to heaven. He saw angels just as he had seen them in paintings and he met all the heirs he had remembered in his will. He knew he was awake for he brushed off his cigar ashes from his jacket. The picture disappeared suddenly as though a theatre curtain had dropped, hiding the scene, and he called himself an old fool. Yet a picture of his stay in heaven recurred several times in later years, and now he conjures up this picture when he wants to blot out disagreeable thoughts.

Women, too, have such bizarre imaginations but it is much more difficult to dig them out. In the very few cases in which I have been able to dig below the surface I have found an erotic element despite absolute denial of any erotic sentiment or feeling. We must remember that the female climacteric creates a much greater change in the personality of the individual than the male climacteric, that this change involves the mentality as well as other physiological factors. In the male the seminal vesicles fill more slowly, libido and potentia wane gradually, the emotion of love which is founded on the instinct of race preservation is weakened and may disappear entirely. In the female the much more rapid and profound changes wrought during the menopause are reflected in her changed mentality; intellect, emotions, and will. While the aging mind permits wide diversions and variations in the intellect, the changes in the emotional sphere are in degree rather than in kind. The emotions are blunted, but the exhibitions of the emotions are more pronounced. The individuals become more demonstrative, yet the emotion itself, love, hate, fear, grief, joy, etc., is shallow and soon passes away and is forgotten. A woman who could hold herself in check in earlier life when her children and her parents died, after the menopause wept when she saw a funeral and still later went to funerals, even to the funerals of strange children and colored persons, to weep with the mourners. She would then return home, forget her shallow grief and might discuss a comic movie or some cooking recipe. Many men in their postclimacteric period find a secret delight in being called a Lothario, a Don Juan or some similar name applied to promiscuous lovers, and give the appearance of being in love, even infatuated, with the members of the opposite sex long after it is no longer possible to simulate the fervor of the early emotion.

There may arise in the aging mind odd variations of the emotions, odd likes and dislikes, loves and hates, joys and griefs, hopes and fears. Some aberration of normal emotions may be found in almost every person. It may be the fear of being buried alive or of retribution in a fiery hell after death. Husband or wife may develop sudden jealousy without any cause for suspicion. In one case, a father suddenly questioned the paternity of a married son and developed so violent a hatred of the son that he omitted the latter from his will. The maternal instinct may account for some of the peculiar likes and dislikes, loves and affections of middle-aged women, but how can we account for the love, affection and care bestowed upon a lot of uninteresting, decrepit, unesthetic old women who make impossible demands and require extraordinary attention from a middle-aged boardinghouse keeper. This is an extreme case of maternal instinct. We often hear of elderly persons who show extraordinary affection for criminals or animals, especially cats and dogs, even to the neglect of their own families. These are exceptional cases showing abnormal trends of natural emotions. Ordinarily, in the aging mind the reactions to emotions are more pronounced while the emotions themselves are more subdued, and these persons will laugh or cry upon slight provocation, show rage or fear, joy or sorrow, when there is little cause for such emotional outbursts.

The will is, perhaps, the least affected of the mental functions in the aging mind. Aging people become more stubborn, adhere more to obsolete or preconceived notions, and are less susceptible to reasonable argument. Occasionally one will accept new ideas without question from one person after rejecting the same idea from another. A well known manufacturer will introduce in his shop any new idea submitted by a foreman after he had rejected the same idea suggested by his son who was in charge of the shop. Sometimes a middle-aged patient makes up his mind that he will not carry out a physician's orders, yet the same orders given by another physician are carried out to the letter. These patients are like willful, unreasoning children, controlled by whims of the will.

Conclusions

In this paper I have given examples of extreme variations in the functions of the aging mind. In some instances we are able through tactful appeals through the

intelligence to overcome the mental defects or aberrations but all show the weakening of the intellect, emotions or will as they are apt to appear in the aging mind.

Discussion

Malford W. Thewlis, Wakefield, R. I.: For years Dr. Nascher has been watching himself grow old. The strange thing is that he doesn't seem to age. In fact, his mind is just as active today as it was when I first knew him twenty-seven years ago. I have enjoyed his paper. I was particularly impressed by his statement that the old man who falls asleep in church or at the theatre is not inattentive, but excessively attentive, and this brings on mental fatigue. In a personal communication Nascher discusses his own paper. I'm certain that I could not do better than quote his own words.

"One point I'd like to make is to encourage old persons to feel, act and appear young; to instil the spirit of youth. Give them an incentive to rouse them out of the senile slouch. Flattery may do it, or an economic benefit, as I did in the City Farm Colony when I raised the number of workers in less than a year from 175 to 650 out of 850 employables, by giving them a monthly reward of fifty cents in tokens good in the community store. Most of them had been bums, hoboes or beggars, but on pay day they came in washed, combed, shaved, and with shoes shined and clothes brushed. I would like to stress this: encourage old persons to take as much care of their personal appearance as they did in earlier life."

I should like to review the aging of geriatrics. As you all know, Dr. Nascher is the "father of geriatrics". The term "geriatrics" was coined by him in 1909 and his first text-book appeared in 1914. It was in 1916 that Dr. Nascher invited me to attend a meeting of the New York Geriatrics Society. Several notable men were present, among them Robert T. Morris, Edward W. Lee, Parker Syms, and Howard Lilienthal. As I recall, only two meetings of the society were held and Dr. Nascher left his practice in 1916 to go into public welfare work. Seeing the workings of the New York Geriatrics Society and how Nascher had organized it, gave us the idea of forming a national society, which later became an international organization.

Dr. Nascher has always been interested in geriatrics and is as much so today as he ever was. It seems to me a fitting tribute to him that this meeting is being held in his honor and also that he will be with us tonight at dinner. If he continues as he is now, I see no reason why he should not be an active man at one hundred. Certainly his advice and spirit have meant a great deal to all of us who are interested in geriatrics and from him we have taken heart to proceed. Therefore, I may say that this meeting really is dedicated to Dr. Nascher, the "father of geriatrics".

ALCOHOL AND THE SOCIAL TENDENCIES OF MEN

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Dionysos, Greek god of wine, occupies no insignificant position in mythology. There is much dispute as to his origin. It is not surprising that he should have been the subject of conflicting opinion. Homer or the ancient critics rather snobbishly disparage him, for he is mentioned only in the passages that are held to be apocryphal. Dionysos was a son of Zeus, estimable parent, and Semele said to have been mortal. The more staid Perseus, also a son of Zeus, stands in some antithesis to Dionysos. Dionysos was born prematurely due to the thundering behavior of his father. His mother did not survive long. The stories woven about him include the religious ritual, orgies, much adventure, gaiety, and the serious business of vine culture and agriculture. Dionysos sometimes appears as effeminate on the surface and more vigorous below. The rites surrounding him seem to make him something of a Pied Piper among women. Some of the Byronic Don Juan adventures are reminiscent of those of Dionysos. Dionysos also rises to acts of considerable violence if necessary and the concept of "madness" is involved in the legend.

It seems that Dionysos is very much the prototype of the average drinker who is serious about his drinking yet fun-loving and gay and at such times attractive to women. Here no effort will be made to study types of drinkers or to examine such problems as why a drinker may neglect his family or beat his child. Such examination is not the purpose here where mythological gods and modern cult practices are the main theme. Underneath the surface of Dionysos or the Dionysiac would seem to lie the insecurity of a critical origin from a mortal and meek mother (Semele) and a rather tempestuous father (Zeus), not a rare combination in many drinkers of today. Feminine and yet cruelly violent when necessary, Dionysos causes ultimate havoc among men because of his ambivalence, dual attitude and action, and finally ascends with his mother to live with the gods. Dionysos fails when he attempts to become Promethean, for which he has neither the liver nor the cunning. Dionysos and wine are analogous to Persephone and her love of flowers.

That the Greeks should have connected all of this with a ritual and part of a religion may seem strange today. Further examination may show that the two periods are not so remote from each other. Since the time of the Greeks, harvesting still is celebrated in wine producing countries where sustenance through commerce in wine is important. Thanks of a religious sort are then given. A very rough definition of religion would be to call it a combination of regulation, ritual and reverence for the ritual and regulation. Greek polytheism would readily admit a Dionysos. Today when various religions live side by side in something of a polytheism, the Greek deities are not really excluded, but in fact included as minor religious devices, for instance the use of sacramental wine.

The first wisdom in not drinking at the Socratic banquet was that too much had already been drunk on previous days. In Kierkegaard's banquet there is the use of wine on its highest level, where men drink that

they may speak openly, honestly and without sham, fear, or threat. Alcohol is not altogether the bane that is described in modern writing on the subject, nor is it all that it is said to be by the drinker. After some study, an impressive factor in modern drinking seems to be the wealth of ritual inherent in its pursuit. Of course, all human activity has ritual and no one can survive very well without some regulation in life, but the ceremony about drinking seems much better developed and constant than about many of the common regulations of living. Herein the average is described and not the extreme or exception.

A bar-room, tap-room, or grill usually is conveniently but not overly lighted. It is subdued, in contrast with the modern tendency to overlighting. Its tradition for long has been to be walled by mirrors, as if each man were constantly eyeing himself through conscience or perhaps in a narcissistic way, as if preening in a beauty parlor. That all who stand at a bar face in the same direction is a discipline in which too free mingling is prevented. Some circular bars, dictated by the needs of space, have greater formality. Cross-bar familiarity is not within decorum.

The bottles, various, attractive, and animistically named after woodland deities (animals, flowers, or abstractions) are set up with meticulous order and polish like bottles of tonic at a barber's, bottles of perfume on milady's dressing table, candles in a candelabra or saints in their niches. (It is interesting to note that cigars commonly tend to be named after women.) Bars usually are kept quite clean, neat, and punctilious. Even the sawdust and cuspidors of primal America were attempts to instill a sense of cleanliness, order, and propriety about the whole business. It might be said that there is a similar order in many other human activities, but that is just the rub, to show that the whole problem of drinking, contrary to the overmoralistic view, even in this is ritualized in an average way. Bartenders have not been given parole authority over their customers when they leave the bar.

And after all, who is more sanctimonious and who has a more serious mien than the hierophantic bartender overseeing his flock, keeping order, frowning at the excessive drinker, ejecting him if necessary, artfully initiating the novice into the mystery of concocting and consuming spirits. He is as deft and accurate with his mixers and glasses as the magic priests of old.

The tone of bars is one of ease, conviviality, and expectancy. Men lose their age long hostility; the thunderous Zeus is suppressed, occasionally breaking forth in some brawling fellow who is suppressed in turn. "How much can you hold" might be interpreted to mean, "How well do you battle with your father?" Something of a holy conspiracy of brothers is set up. There is general good will and little suspicion. Troublesome Eve is ejected except for a very modern tendency to admit her again to these Bacchic rites. Does all of this indicate homosexualism? Not necessarily. In large part it is what may be called homosocialism—men expressing their vital tendencies in social activity. The attitude at a bar is simple human fellowship in a good if not the best sense.

The drinker is pietistically sensitive to a violation of the rites of drinking as a man would be if another came into his house and kept his hat on or if some disrespectful word were uttered on entering a church. There must be good grace to begin with. If one does not accept a drink in a drinking group one becomes highly suspect—the drink is like the handclasp of friendship. Defenses are to be let down—all guns are on the table. The *why* is not asked but one is urged to conversion on the truly religious basis of a positive gain; a suggestion of bad manners is indicated if one does not drink. Hardly anywhere does man show such generosity to his fellow man as at a bar. Contrary to the business world there actually is considerable vying to purchase drinks. If in one's turn one does not enter into the spirit and buy a round, it usually is ignored as if the profaner needed another drink in order to be converted. Revelations otherwise undreamed of are made under the influence of liquor. Indeed, the bar is a very counterhouse for the unblubbering exchange of information where many a wheel of justice is set in motion. It is only the amateur who boasts of how much he can drink. If, the next day, one suffers from excessive drinking, the drinker, with true faith, will advise a morning drink. There is an etiquette of not reminding the drinker of what transpired the night before. It is as if the confessional had not come about, as if secrets had not been revealed; there is forgetting. If things were revealed one might have to recant. However, it is proper to reveal the lighter and gayer moments that occurred.

Of all trades, it would seem that that of politician flourishes best at the bar where one may discern friend or foe. It is truly democratic, and the politician, unpleasant as he may be in many respects, is the true symbol of democracy. He is warm and cordial yet scheming. His methods of procedure, if successful, are blared forth rather than concealed in shame; success alone counts. He is neither wealthy nor poor: he connects the classes. He is neither polished nor uncouth. He is ready to lead one on high or cast one down. He wants sanction, and one of his first tests is the willingness to drink with him. He is a believer in you, himself, and mankind. His is the faith of the personality in open action and striving.

It would be possible to go into many more of the manifestations of the cult-like structure in drinker groups. It is incorrect to consider drinking as an unmitigated evil and evidence of license as it is incorrect to accept the view of the talented drinker that his cult is the greatest of blessings. The purpose of this paper then is served if it is shown that there is order and ritual even today in drinking groups. It would be a distortion of history to feel that Dionysos was revered by all Greeks. The Greek gods did not have the unchangeable nature one finds in a well-knit monotheism. Plato in his Laws proposed regulation of drinking that was just a little more than mere temperance. Socrates, of course, was of a superior order and could take it or leave it alone; he was adamant to both inner and outer compulsions that were not fully charged with reason and common sense.

Where greater gods do not appear, there Dionysos has a tendency to cast his sway. It does seem likely that mere prohibition is not a solving portent for the modern problem of excessive drinking. The values and satisfactions, some indicated above, would have to be replaced by their equivalent in the social structure. As may readily be seen, this would be no easy task.

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PSYCHOSOMATIC OBESITY

*With Comments on 924 Cases**

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Increasing interest in the subject of overweight has finally resulted, in many quarters, in the realization that etiologically, clinically and therapeutically, the average case of obesity is a typical psychosomatic problem. The glandular or endogenous form of obesity is unusual; the alimentary form, conditioned by environmental maladjustment, is very common.

In the rearing of children, parents often stress eating above all other interests in life, thus moulding a personality that is to become psychologically and physically defective. When puberty is approached the already established obesity becomes embarrassing to parents and youngster alike, but nothing serious is done about it. Sooner or later the fat boy or girl, sensitive to the gibes of schoolmates, acquires an inferiority complex and seeks an outlet in still more food. Thus the vicious circle is complete, and this situation may continue on to adult corpulency.

The obese adult owes his plight either to the juvenile philosophy of "eats" as the paramount interest in life, or to maladjustment to the multitudinous worries and tensions of current existence. Instead of resorting to mature rationalization, the individual seeks an outlet in the solace and relief of eating beyond bodily needs.

For every person who worries himself thin there are three who eat their way to obesity. And while in the few the thinning process of worry and tension undergoes spontaneous arrest at a fairly safe point, in the many the fattening process may continue to unfortunate results.

The physiological explanation for the mental relief experienced by overeating is thus stated by a distinguished physiologist: "There is a constant fight between the belly and the brain for blood." The full stomach, demanding more blood at the expense of the brain, lends a sense of composure, of relaxation, and even of happy indolence and repose to the emotional centers. Seeking this outlet habitually despite increasing weight, the tensive individual becomes the calm, jolly, rolypoly "fatty".

Psychology of Obesity in Youngsters to Age Sixteen

Several "fatties" in the same family are not necessarily the result of heritage, but of common dietary habits. A table laden with highly nourishing food is indulged in by all and in consequence all become obese. Recently I had under observation two brothers, sons of unusually obese parents. One of them, aged fourteen, weighed 235½ pounds; the other, aged sixteen, weighed 223 pounds. It was revealed that along with fattening food of every description, these boys, fond of bread (their father is a baker), were accustomed to taking approximately a loaf of bread at each meal.

Under simple psychotherapy, dietetic discipline can render acceptable a daily intake of one thousand calories or less until the goal is reached, when a maintenance diet can be formulated. In dietetic computation it is well to arouse a scientific curiosity in the youngster. Take, for example, the following case:

Herbert, aged fourteen, weighing two hundred pounds, was about eighty pounds overweight. The great folds of fat over his chest and abdomen made him unhappy. He was especially self-conscious when swimming, where he was taunted and ridiculed by his companions. The prospect of reduction to normal aroused his keen interest. "Suppose," I remarked, "you were stranded on a lone island, with no food, except for some drinking water. Do you know, Herbert, how long you could hold out before being rescued?" "About two weeks, I imagine," ventured Herbert. "Much longer," I corrected. "You could hold out without eating for at least thirty days, perhaps forty, and when rescued at the end of that time, you would be quite normal in weight." "You mean that I could live off my own fat for forty days?" "Yes, Nature would live on your extra eighty pounds and like it. But we won't go to this extreme. You will lose your excess fat in about eight months, if you help." Herbert helped. Within little more than the time stated, on a planned diet, appropriate medication, and psychotherapy, his weight became normal, and his self-confidence and happiness were restored.

In contrast to the haphazard spirit of self-expression, the development in the youngster of a wholesome table personality should be the responsibility of every family in which there is a tendency to corpulency.

The fat youngster's behavior pattern must be studied. The old adage, "familiarity breeds contempt", may apply even to the child-parent relationship. In these circumstances it is well to have a stranger step into the picture—the understanding physician. He must not be a stranger long, but quickly become the youngster's respected friend and "pal". After the first interview the youngster should see the doctor alone. This makes for a sense of mutual trust and confidence. A diary kept by the patient of the daily food and fluid intake may expedite results.

The following is a good example of well-timed psychotherapy in the case of an obese adolescent girl whose cooperative spirit was well rewarded:

Z. A., aged sixteen, a school girl, whose height was five feet five and a half inches and her weight 230½ pounds, had been gaining weight since the establishment of menstruation four years before. The parents and the referring physician felt that this was a hopeless case, as previous efforts at reduction, aside from a transient drop of about twenty-five pounds, had proved futile. Somehow, after a brief determined effort, the weight would quickly return and disappointment and unhappiness would reign in the household.

The past medical history and laboratory data were negative. While there were some vague evidences of pituitary involvement, the etiology was predominantly alimentary. The cosmetic effect on the physiognomy of this youngster with nearly one hundred pounds excess weight was embarrassing to all except the patient, who

*We are here discussing the average cases of alimentary obesity, comprising more than ninety-five percent of all cases, in which the weight is twenty or more pounds above normal.

appeared little concerned over her plight. She frankly confessed her inability to control her appetite.

Here was an urgent need for practical psychotherapy, which seemed the missing link in previous treatment. To overcome her sense of futility, to instil a healthy self-confidence—in short, to reeducate the youngster in true personal and social values, was the crying need.

This pabulum, supplemented by a one thousand calorie diet, and the use of well selected medicaments bore fruit. Within three months there was a reduction in weight to 180½, a drop of fifty pounds. But soon the youngster became somewhat weary of self-denial, and when two months later there was a further reduction by only six pounds, we suspected that there was some clandestine eating. This was confirmed by a note from her father, which revealed that the prescribed diet was substantially supplemented by "eating out". This reduction by fifty-eight pounds had made quite a change in the patient's appearance. She was able to wear attractive clothes, and had become rather good looking. But there was imminent danger of a relapse.

At our next interview we discussed frankly the matter of pride in appearance and the current retardation of progress. I expressed my admiration for her sportsmanship in the prolonged ordeal, and for her sincere and conscientious teamwork. "Have you ever been accused of stubbornness?" I queried. She laughed and retorted, "yes, many times, especially when I would not stick to diets given by my doctors". "Well, said I, "Hold on to your stubbornness and it will help you. Harness it in the right direction; we then call it perseverance. Hold on to this perseverance and you will soon reach your goal! Continue being the good sport!" The patient promised to be "stubborn in the right direction" and left us in excellent spirits. Several days later, to follow up the psychic advantage, we sent her the following note:

Dear Z:

Please remember our conversation of November 20th, in which I pointed out that every extra morsel of food, every crumb of surplus beyond your prescribed diet means the likelihood of arrest of progress or even a gain in weight. I trust you to carry out the promise you made to cooperate without question.

There are excellent motives for your enthusiastic teamwork. In the first place, you will be safeguarding your future health. Secondly, of equal importance, is the fact that some day you may want to get married, and we all wish you to be a beautiful bride. Of course, no one wants to be a fat bride, and the time to begin preparing to be a beautiful bride is right now.

With best wishes and regards and looking forward to an excellent report from you, I remain, yours most sincerely

Since this note was sent events have moved along pleasantly. By the end of the tenth month of attention (corresponding to the present writing) the patient weighed 158 pounds, a total drop of seventy-two and a half pounds and became a strikingly good-looking young lady with a high sense of pride in her appearance. She has overcome her craving for excess food and watches her weight meticulously. While she still weighs about twelve pounds in excess of the goal, this is expected to disappear soon.

Obesity in Patients Age Seventeen to Forty

Obesity in the young adult presents the same problems as in youngsters, except that effects are more firmly established and the development of a realistic spirit of cooperation presents greater difficulties. The following case history is typical of a rather stubborn type whose main objective in life was to reduce, but without sufficient effort:

Miss B. L., aged twenty-eight, height sixty-four and a half inches, weight 324 pounds, with no particular occupation, was eager to weigh 130 pounds, a reduction of 194 pounds! She promised to leave no stone unturned in her efforts to lose "that horrible excess baggage". She admitted having made such promises to other doctors, but, as she put it, "they never explained the seriousness of obesity to me, and after losing about twenty-five pounds, I would invariably gain it back, plus some more".

Her weight was normal until her thirteenth year when menstruation was established. With the increasing weight menstruation became infrequent and irregular. The past medical history was unimportant. A few years before, the patient lost both parents within a month. She found herself unhappy in her environment with her brother and his wife and, consequently, she ate more than ever as an "outlet".

Physical examination revealed a fairly equal distribution of excess adipose tissue with a tendency toward the pituitary type. X ray examination of the sella turcica was negative. The blood pressure was 220/110, though laboratory data, on the whole, were negative. The basal metabolic rate was plus six percent. The diagnosis was predominantly alimentary obesity with sequential arterial hypertension.

At the outset the patient was warned that unless results proved that she was cooperating sincerely, we would refuse further attention. On the other hand, the reward of sincerity in teamwork was pointed out—the probable gradual reduction of the blood pressure and the return of menstruation to normal, the happiness of being able to appear in public without attracting attention, and the fact that at her age, normal weight would mean an attractive face and figure.

She seemed impressed with these efforts at constructive psychotherapy and we felt that with reasonable teamwork for a year or thereabouts she would be quite close to normal in weight. Within three months the patient's weight dropped thirty-five pounds, to 289. The blood pressure, too, responded, so that by now it was 170/90. At this point she became noncooperative as evidenced by a gain of six pounds three weeks later, and despite psychotherapeutic efforts, there was a steady increase for the next several weeks until she again reached three hundred. We soon discovered the cause of this difficulty. For several weeks she had been working in a delicatessen store, and had recently changed to a job in a bakery. In each place there was the irresistible opportunity for gorging on thousands of extra calories a day. Appeals to her sense of pride and instinct of self-preservation notwithstanding, she ignored our orders and we were about to refuse further attention when she disappeared from our view.

An example of persistent blind parental indulgence is emphasized in the following case:

Mr. H. C., aged twenty-four, height six feet one and a half inches, a clerk, weighed 366 pounds. He was already suffering from unmistakable signs of cardiovascular strain from overweight. At the age of three he had an attack of influenza, following which, through parental indulgence, the process of overfeeding was begun and, according to his mother, "he soon became very

large". The mother, too, was an obese person and a degree of obesity in this her only child was taken for granted. When the boy reached adolescent years he already weighed one hundred pounds too much. At this time he lost his father, and his mother now indulged the boy more than ever in all sorts of rich foods.

The past medical history was otherwise unimportant. Physical examination revealed no glandular stigmata. The basal metabolic rate was plus sixteen percent. Other laboratory data were negative.

This was clearly a case of alimentary obesity aided and abetted by an indulgent mother. A regime of therapy, including a dietary of 1500 calories a day was prescribed, and within four weeks the patient weighed 329—a drop of thirty-seven pounds. He was delighted with his progress and "ability to get around much better" as he put it, and promised enthusiastically to continue obeying orders. A week later his mother phoned and in no uncertain terms told us that since her only son was starving to death (at a weight of 329 pounds) she would have no more of doctors, and that her son would henceforth eat as he was taught since childhood!

Obesity in Patients Past Forty

In youngsters and young adults the skin is quite elastic and follows, without tangible cosmetic embarrassment, the receding tissues from which the excess adipose tissue is disappearing under a reduction regime. This is not altogether true of those approaching middle life. The formerly obese patient past forty, reduced by fifty to one hundred pounds or more, *feels* and *acts* decidedly younger than before, but such marked reduction may be at the expense of outward appearance. The face, arms, thighs and abdomen may present loose folds of skin that are embarrassing. This is no argument against reduction, since overweight is a greater cosmetic problem, plus a life-abbreviating malady. In these cases it is wisest to stop reduction at a point about twenty to thirty pounds short of the goal. This often prevents cosmetic difficulties, especially as applies to the face. The following case is a typical example of this problem:

Miss B. M., aged forty-five, a nurse, five feet two inches in height, weighed 240 pounds. She had weighed 290 pounds seven years before but tried self-reduction and had dropped fifty pounds to date. Physical examination revealed a blood pressure of 220/110, and heart somewhat enlarged. Other physical signs, as well as laboratory tests, were unimportant. Treatment was highly successful and cooperation perfect. In five months her weight dropped by sixty-five pounds to 175, and the blood pressure was reduced to 145/85. At this point it was observed that while the facial skin presented no definite cosmetic problem, the upper arms had great folds of inelastic skin hanging from them. No further weight reduction was suggested since the blood pressure and other problems incident to obesity had completely disappeared.

Friends and Neighbors

In addition to parental indulgence we may have trouble with fat friends and neighbors. A peculiar kind of jealousy often enters the scene. The following is a typical example:

Mrs. K. F., aged forty-five, a widow, five feet two inches in height, no occupation, weighed 218 pounds and was almost a cripple from top-heaviness. A careful history and physical examination revealed that this was a case of purely alimentary obesity induced largely by the nervousness following the passing of her husband. She appeared serious in her promise to cooperate, and lost her first thirty-five pounds on schedule. Still weighing 183 pounds, she nevertheless felt and looked considerably better than before, was able to walk securely, and was determined to continue cooperating until the goal was reached.

At this point, one morning, a strange voice over the phone asked for some information on Mrs. F. The voice was solicitous and began like this: "Mrs. F. is terribly sick; she looks like a bag of bones". I immediately suspected that this was for the purpose of arresting Mrs. F.'s progress. "Who are you?" I asked. "I cannot give you my name, but I am a good friend of hers and I would like you to tell me . . . "What is your name?" I insisted. "Mrs. Gray, and you know she is very sick . . ." When I saw the patient again I inquired whether she knew a Mrs. Gray. She did not. I then told her that I believed she must have a jealous fat friend. She laughed and confided that as a bridge addict she had a number of jealous fat friends, and they had been begging her not to reduce.

Additional Psychotherapeutic Comments

The fat patient should be convinced that it is much safer and saner to go about half hungry for a few months of proper dieting than to be fat for life. The fatalistic attitude of the occasional patient who says that he desires "a short life and a sweet one" is contradictory and should be combatted promptly. A life is short by reason of its bitterness, not sweetness, unless by sweetness is meant a complicating diabetes.

In every case of obesity the physician must ferret out the psychological etiological factors. In chats with the patient a simple explanation of causal relationship may start him off to recovery. The dangers of obesity must be emphasized; we must direct his behavior toward a more mature emotional stability.

Incidentally, we must be on the alert for those patients with pre-Graves' disease obesity presenting the earmarks of "Graves' constitution". The pathognomonic restlessness, seeking an outlet in excessive food, results in corpulency. Sooner or later, especially on the super-imposition of a psychic trauma or as the reaction to self-drugging with thyroid extract for obesity, Graves syndrome may "catch up" with the individual and we are faced with exophthalmic goiter and its typical conspicuous weight loss.

We must emphasize that excess fat is parasitic, demanding much and giving morbidity in return. The fat man may be relatively immune to tuberculosis, nervous and mental disease, constipation, digestive disturbances, and a grouchy personality. The disadvantages of obesity, however, far outweigh the advantage. Among the maladies to which the fat person is unduly susceptible are diabetes mellitus, heart disease, arterial hypertension, arthritis, gallstones, hernia, varicose veins, undue frequency of bone fractures and a high mortality incident to operations.

To state, with one authority, that overweight is classifiable into enviable, comical and pitiable types is unfair to the victims. Obesity is neither enviable nor comical; pitiable, yes, and often tragical. It is the painlessness of obesity that lends indifference and procrastination and carelessness to a situation that is urgent.

Were the average case of obesity associated with pain, this would add anxiety to the clinical picture, and the patient would seek timely relief and the recapture of normal life expectancy.

With the aid of psychotherapy, obesity is generally the easiest of all maladies to prevent and cure.

Results in Our Series

The following table indicates the end results in our series of cases, followed up for a period of at least one year in each case:

End Results in 924 Cases of Alimentary Obesity with 20 to 150 Pounds of Excess Weight

Results	Loss of Excess Weight	Number of Patients	Percentage
Excellent	over 90 percent	554	59
Good	" 75 "	185	20
Fair	" 50 "	102	11
Poor	" 25 "	27	3
No results because of poor cooperation		56	7
Totals		924	100

A person encumbered with a load of fatty baggage for many years, and who within a few brief months finds himself relieved of this load, has undergone a process of virtual reactivation. He finds himself living a new and more satisfying existence. Psychologically and physically, such a person has dispensed with a heavy redundant overcoat and is now free to work and play. The extent of this freedom—especially if the reduction is fifty pounds or more—is expressed in a buoyancy that can be appreciated only by the one who has been liberated from this encasement.

Conclusions

1. Alimentary obesity is a psychosomatic condition in which the psychic is responsible for the somatic plight.

2. Psychotherapy is of primary importance in the prevention and management of obesity, serving (a) to effect a more satisfactory adjustment between the patient and his problem, and (b) to educate the patient to adopt a rational attitude toward a preliminary submaintenance and eventual maintenance diet in the achievement and perpetuation of normal weight.

3. The end results of treatment of a series of 924 cases[1] of alimentary obesity, observed within a period of ten years, is reported. Results were excellent in fifty-nine percent, good in twenty percent, fair in eleven percent, poor or no results in ten percent. With favorable cooperation, treatment of obesity is satisfactory.

1633 SPRUCE STREET

[1]These patients were observed in clinic and private practice over a period of ten years.

PAIN RELIEF IN SCIATICA

DANIEL C. REYNER

Atlantic City, N.J.

Sciatic neuralgia is a troublesome condition, as the dull ache which occurs in the beginning of sciatic neuralgia may bother the patient very little. However, as the pain increases it becomes burning, sticking or lancinating in character. If, unfortunately, the pain becomes chronic, it causes much discomfort to the patient, and presents a problem for the physician who is called upon to render relief.

Various methods of therapy have been reported from time to time. These include removal of foci of infection, rest, analgesia and physical therapy, and various injection treatments. Among the latter may be mentioned the epidural injection of physiological sodium chloride solution; fever therapy and surgery have also been used.

I have been using with gratifying results an injection mixture consisting of drugs with potential anesthetic value. In this report I desire to report my experiences for over five years with the injection of the combination of such pain relieving agents.

In 1941, the usefulness of injecting intramuscularly a combination of gomenol, eucalyptol, guaiacol, iodoform and camphor in olive oil for the treatment of sciatica with low back pain was the subject of a preliminary communication by me (1). Eight cases thus treated responded with gratifying results. At that time, the rationale for the preparation and its method of use were outlined. Since that time I have used the same medication, with no auxiliary treatment, in twenty-five more cases. The results have varied from complete relief from pain after one or two injections in the gluteal muscle to partial relief after six injections. Gobromol[1] did not fail to give some relief in a single case. In those cases where relief of pain was not dramatic, the condition was present for a longer period of time before the treatment was instituted. Experience with the medicament suggests that if the sciatica is treated early in its origin, a complete or reasonably complete relief can be expected.

Of the twenty-five cases thus treated, four typical cases are cited, as follows:

Case Reports

Case I.—M. A., a man, was given one injection the day following his first attack. The pain was so intense he could hardly walk. Several hours later two cc. gobromol was administered, and there was complete cessation of pain. The patient received no further injections. Six months later he had another attack and received three injections of gobromol with complete relief.

Case II.—Dr. R., a retired doctor, aged eighty years, gave a history of sciatica for many years. When gobromol was started his pain was severe and was undermining his health. It required three injections for the acute pain to disappear; all that remained was a feeling of numbness. Six months have passed and he has had no recurrence.

Case III.—E. G., a woman, aged fifty-four, had a left sciatica for two weeks, with low back pain. It was her first attack. She received two injections of gobromal and was completely relieved of her pain.

[1]Each two cc. ampule of Gobromol contains gomenol 0.1 Gm., eucalyptol 0.08 Gm., guaiacol 0.10 Gm., iodoform 2.02 Gm., and camphor 0.05 Gm., in olive oil, q.s. It is a product of Endo Products Inc., Richmond Hill, New York.

Case IV.—In the patient, one recent case, Mrs. F., consulted me after being confined to her bed for nearly three weeks because of pain due to left sciatica. It was her first attack. She was slow to respond to gobromol and about eight injections were required before she had sufficient relief to enable her to return to her work.

The use of this combination of drugs in sciatica over a period of three years has given me the strong impression that some specific analgesic action is available through its use. At times, the relief of pain is spectacular. In not a single instance did it fail to lessen the pain in some degree.

No other medication was given to these patients. Most of the twenty-five patients complained of an associated low back pain. In all instances, where the sciatic pain was relieved, the backache disappeared

No untoward reaction of any kind has been observed from the use of gobromol. The injection itself, using the same technique as used previously, is painless and in practically all cases, some diminution of pain appeared within twenty-four hours.

Reference

1. REYNER, DANIEL C.: Sciatica with low back pain—an injection treatment. MED. REC. 6:154, 1941.

THE PHYSICIAN'S ATTITUDE TOWARD PROSTITUTION AND JUVENILE DELINQUENCY*

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The problem of juvenile delinquency in girls, which is stirring the nation, is replete with the most serious consequences which reach down to the very fabric of society. In the background, yet basically pertinent, is the age-old connection between the sex urge in men and prostitution by women. Prostitution is as old as mankind, but it grows most luxuriantly in war time.

According to official reports, most cases of contemporary juvenile delinquency involve sex activity with members of the armed forces. We seldom realize that the average virile young man thrust into a uniform and regimented into a new and restricted life does not automatically shed his elemental sex instincts, however desirable that may be from the military and social points of view. He is the same sexually predatory human animal he was in civil life, perhaps more so, yet we expect him to become a Sir Galahad over night. Whether we like to admit it or not, the average unmarried man satisfies his instinctive sex urge through the medium of prostitution,—commercial or otherwise. It is inevitable that the predatory pressure on young girls increases in direct proportion to the successful suppression of commercial prostitution.

It must be remembered that all men and women are not constituted alike in their sexual needs. We are all born with an inherited sex potentiality which makes itself manifest throughout life in a corresponding coefficient of sex virility. In some it is strong, in others weak, and in between the extremes there are as many degrees of sexuality as there are individuals. It is not always a simple matter to determine whether for this or that individual long-continued abstinence is compatible with mental and physical well-being. It all depends on his sex endowment. Abstinence for long periods, and this implies psychic as well as physical abstinence, may be quite natural for the individual with a low sex potential because the sex factor is an unimportant element in his life. In the strongly endowed, however, the sex factor is a powerful driving force which often dominates his entire personality.

We cannot therefore establish a uniform rule of sex conduct that will apply with equal force to all the young men in the armed forces. Nor can we expect, though we may hope, that the more sexually vigorous among them will eliminate their inherent sex urge for the duration and comport themselves in the celibate manner ordained for their benefit by well-meaning elderly people who probably have forgotten that they were ever young themselves. To entertain such expectations is neither rational nor scientific and merely invites, if it does not create, the horrifying conditions we are facing today.

As this is being written, we are told that the incidence of syphilis in the fifteen to nineteen year age group has increased one hundred forty percent since 1941. We are also told that "for the first three months of 1943 there was an increase of over thirty percent of delinquent children in the New York City Children's Courts. The largest increase was in sexual involvement on the part of young girls . . . "Young girls, through feelings of patriotism, will engage in sex acts with members of the armed forces, sometimes for pay, but frequently as a patriotic gesture". What other emotions these girls may have had, the writer does not say. Similar conditions exist throughout the nation. In San Diego, California, we learn of considerable juvenile delinquency. "Some of the girls were found in cheap hotels", an official report says, "and were known to entertain a stream of visitors. Such a manner of living is not acquired in a few days . . . The fact that many of the girls are very young must add to our concern for them. Some, arrested for having become practically prostitutes, were only twelve years of age when apprehended." There is food for serious thought in the knowledge that these conditions can and do exist after so many years and millions of dollars spent on the suppression of commercial prostitution. The question naturally arises whether prostitution by girls of twelve is an improvement on the old-time commercial type it has supplanted, which was more or less segregated and localized so that it could be kept under observation and under some measure of control.

The present condition is but an acute war-time exacerbation of what has been going on ever since the nation-wide attack on commercial prostitution was instituted. The problem of prostitution and the soldier's sex urge has been a thorn in the side of military commanders in every war in history. Until quite modern

*Abstract of an article which appeared in *The Urologic and Cutaneous Review*, 48:5: 220-223 (May) 1944.

times, it was customary for armies to have their official contingents of prostitutes, who not only served the men sexually but also did their cooking and laundering and mothered them generally. In every instance the venereal rate shot up so rapidly that the women were expelled from the Army after a time, only to be recalled in response to the urgent demands of the soldiers. A recent writer tells us: "Americans, during their occupation of the Philippines established brothels and regulated prostitution for their troops. When the inhabitants objected, the American Government sent a commission headed by Mr. Taft (later President) who decided to continue the regulation in all cities where soldiers were present." And today the same problem exists, but in worse form, with no solution in sight.

The increased incidence of venereal disease, of sexual delinquency, of illegitimate pregnancies and sex crimes is all part of one picture,—the imperious sex urge satisfied surreptitiously under the worst possible conditions, because our moral code has utterly ignored the sex instinct in the unmarried (of both sexes) as though it did not exist. Whether this attitude is right or wrong, wise or unwise, is not the point at issue at the moment; the fact of its being so is merely stated for whatever bearing it may have on the situation under discussion.

The complex problem in which the sex urge and sexual promiscuity are the outstanding factors, centers around a question which is readily stated but not so easily answered: "Is sex activity a physical function like other body functions, a release of pent-up secretions and emotions, or is it an immoral, lustful indulgence in vice"? As a corollary, a second question arises: "Is long-continued abstinence (until marriage) consistent with normal health in the sexually vigorous"? If we knew the answer to these questions and acted accordingly, much human misery could be averted. In the ultimate analysis, these are purely medical questions and should be answered by medical men.

We are confronted by the fact that there is no authoritative medical opinion by which Church and State can be guided. The medical attitude toward sex and its problems, is puzzling and peculiar. As scientific men it is presumed that physicians are sufficiently acquainted with biology and physiology to know that every body function is correlated with the other functions of the body and that all must work in harmony under natural laws which cannot be annulled or even modified with impunity. You cannot suppress one function without injuring the others. The medical attitude toward the sex function is, to say the least, confused. There is a large body of medical thought which seems to regard the sex function in the human species as something of the nature of an immoral practice which must be curbed and subordinated to religious and moral rules laid down ages ago by theologians for the conduct of human society and the betterment of our souls. In other words, paraphrasing Dr. Oliver Wendell Holmes, their medical views on sex are highly sensitive to religious and philosophical influences which more or less completely dominate their thinking on the subject.

On the other hand, there are a few realistic physicians who regard sex objectively as a physiological function subject to fundamental natural laws which cannot be subordinated with impunity to laws instituted by men. Between these extremes are several variants which add to the complexity of the situation. A large body of physicians concede that sex (in the human male) is an imperious dominating force which will not brook denial of its satisfaction; but as to the human female, they apparently believe the sex instinct does not exist; or if it does exist, it has no right to be exercised until marriage awakens the latent instinct. Any exercise of the function by an unmarried female, whatever her age, is *ipso facto* immoral and a sinful indulgence in vice.

Another large group agree that sexuality is a natural function, but it may be satisfied only within marriage; any exercise of this function previous to marriage is an act of immorality and an indulgence in vice. They also believe that unmarried men and women can (and should) go for long periods without the exercise of this function and some, like the late Howard Kelly, go so far as to hold that abstinence is definitely advantageous.

Medical opinion is thus suspended on the horns of a dilemma. On the one hand, recognition of the physiological character of the sex urge and on the other, the inability to satisfy this imperious urge without violation of the moral conventions. Apart from individual opinions of writers on the subject, which are generally prejudiced by their personal moral and religious emotions, there is practically no literature by which we can obtain a true cross section of unbiased medical opinion. Such a cross section would help clarify the present situation and possibly lead to a better understanding and more realistic treatment of the problem.

An attempt was made by the writer to determine the attitude of a large well-informed group of physicians on these and allied questions through a questionnaire distributed to the members of the American Urological Association. A summary of the majority opinion of those who answered the questionnaire follows: Sex abstinence is not considered synonymous with morality or virtue; occasional sex indulgence by the unmarried is the exercise of a physiological function and not a vice; nevertheless, it is not essential to normal health; it is consistent with normal health for men to abstain throughout life or for long periods, but the abstinent man is not the mental or physical equal of the man who does not abstain; prolonged abstinence encourages the practice and habit of masturbation but the habitual masturbator would give up the practice if sexual indulgence were available; prolonged abstinence in men is the cause of various sexual and urinary neuroses, but does not cause premature impotence or pathological lesions in the posterior urethra and adnexa; women can go through life without sexual indulgence, nevertheless the abstinent woman is not the mental and physical equal of the woman who is not abstinent; abstinence does not tend to the development of pelvic inflammation, catarrh, tumors, etc., in women.

It is this confusion in medical thought that makes the solution of our sex problems so difficult. If doctors who ought to know what sex is and what it means to the individual and to the race cannot agree on the fundamentals, it is certainly not to be expected that laymen and theologians will have some rational understanding of the subject. Until medical men apply scientific processes objectively without the injection of their religious and moral aspirations, we cannot hope for an improvement of the serious conditions which confront the nation today and in the future.

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Editorials

Neuropsychiatry

At no time has there been a greater need for the utilization of neuropsychiatry, not alone for those in the armed forces who may require treatment, but also for a great number whose equilibrium has been disturbed among the civilian population. This has been caused by the transference of large numbers into new fields of activity and changed living conditions. Then there are those who are under great tension and anxiety because relatives and loved ones are in the armed services.

The number of medical men who were trained as specialists in the field of neuropsychiatry was considerably limited and we had not too many to meet the requirements of peace time. As many in this field as could be spared were employed in screening the inductees of the armed forces. As useful as the screening was, it fell far short of what one would consider adequate. This was due mainly to the scarcity of trained psychiatrists, and secondly, to the vast numbers of men who were inducted in a relatively brief period of time. Had the screening been more efficient there undoubtedly would have been fewer men discharged from the armed forces because of their inability to meet the psychological requirements. We feel that the need for trained psychiatrists will not be lessened by the advent of victory and peace. The readjustment that will be required from war time conditions to those of peace, we believe will be greater than is generally understood. This holds for the returning men of the armed forces, as well as large numbers of our civilian population.

We are in no position to judge as to what the basic requirements in this field will be in other countries. We are of the belief that in most of the European and Asiatic countries, the great need for food and shelter will be paramount. How the population of these countries where there will be obvious shortages, will react, is hard to determine, but in our humble opinion it will result in a most unhealthy psychological picture. Topsyturvy values will undoubtedly result from despair in many countries. If we are to endeavor to establish a permanent peace, the unsatisfactory mental and emotional, as well as physical status of the population in many of the countries which have been through the major hostilities will undoubtedly prove a great obstacle.

We do not want to encourage the growth of new Hitlers, and this can best be prevented by avoiding the planting of seed in fertile soil which will result in such pathological specimens. If we are to prevent future hostilities, we must endeavor to have healthy, progressive nations, as well as nations who have a healthy and sane relationship with each other. A few more well trained neuropsychiatrists would help. A better understanding of the underlying psychological problems would do no hurt, but we must admit that it is difficult to have a healthy people psychologically when there is a shortage of bread.

Postwar Rehabilitation

Young men and old buildings are being destroyed in the grim battles now in progress in Europe and other parts of the world. In this country, we feel the impact of the war by the men and material which we have thrown into the combat and furnished to our Allies. Naturally we all hope that this vast struggle, initiated by a small group of psychotic persons, will result in a better world. Our cities have not been devastated, we have not lost countless civilian lives through the bombing of cities, nor has our country been the battleground of advancing and retreating armies.

When the war ends, we cannot leave a devastated Europe or Asia to its own resources. We shall be called upon to take care of the immediate physical requirements of many millions who would otherwise be left in a state of chaos and not able to provide for themselves. The example of Italy is rather discouraging. In addition to the material necessities, well-organized and stable governments will be of prime importance.

It seems logical to us that, with the varying degrees of undernourishment and the shortage of housing facilities which have been caused by military measures, Europe for a long time will be in danger of widespread epidemics and a fertile ground for chronic diseases such as tuberculosis. Medical men and medical supplies will be required, this in spite of all that can be done in the way of feeding and sheltering the millions in devastated Europe who will be homeless and will suffer from lack of proper foodstuffs. Millions have been transported from their homeland by the Germans to work in the fields and factories and mines of Germany. These will have to be repatriated and taken care of.

If these various groups of peoples are not taken care of, famine, pestilence and revolutions will result, more destruction will follow, and stable governments will be more slowly established.

We trust that the agencies set up by our government especially for medical care will succeed in this task which we consider so vital. It will be a tremendous job and we feel that, while it is somewhat difficult for us, so far away from the scene of carnage, to visualize the picture, we should give more thought and consideration to the importance of the job which confronts us. If this is not carried out adequately, the postwar tragedy of Europe will be greater than what is now taking place during the period of hostilities.

The Control of Respiratory Tract Infections

In the *Journal of the American Medical Association,* September 9, 1944, there are two articles of the greatest importance which should be read by every practitioner of medicine of whatever "specialty". In substance, both our Army and Navy now have a plan for the control of acute infections of the airways—and the *plan works.*

The first of these reports is written by Colonel W. Paul Holbrook of the Medical Corps, United States Army. He is especially concerned with rheumatic fever. Quoting Dr. H. F. Swift's survey of New York State in 1938, the assertion is made that there are four hundred and sixty thousand persons in the United States suffering from rheumatic heart disease! Colonel Holbrook had material covering twenty-five thousand beds and eight hundred thousand troops. The posts chosen for study were in areas where rheumatic fever is common, intermediate or rare, in order to get a cross section of climatic and other influences. Colonel Holbrook says: "The exact etiology and pathogenesis of rheumatic fever is still unknown." Then comes an important statement: "Our experience and that of others indicates that in a majority of instances the development of the acute rheumatic syndrome is related to a *preceding hemolytic streptococcus infection.*" This bears out an observation which has long been known to ear, nose and throat specialists. Again, he says: "—approximately fifty percent of the admissions for respiratory disease showed clinical and laboratory evidence of significant hemolytic streptococcus infection." During 1943, our soldiers spent fourteen million days in hospitals because of respiratory infections!

The remedy is sulfadiazine as a prophylactic and as a cure. From one half gram to one gram is given daily, but six grams given in three days reduced hospital admissions seventy-five percent during a twelve day test. There were no renal complications, no leukopenia, no deaths from the drug, but rashes did appear on the skin now and then. This is truly a marvelous advance in the control of rheumatic fever as associated with streptococcus infections of the air tracts, for ". . . it appears that the reduction in rheumatic fever parallels that of respiratory and streptococcic diseases."

Immediately following Colonel Holbrook's article is one entitled, "The Prevention of Respiratory Tract Bacterial Infections", by Commander Alvin F. Coburn, MC-V(S), U.S. Naval Reserves, Washington, D.C. Dr. Coburn says that "the Navy's enormous loss due to Streptococcus hemolyticus was only one of the compelling reasons for instituting a streptococcus control program." The aim was to prevent rheumatic heart disease among Navy personnel. The administration of "one gram of sulfadiazine daily to all hands at Activity A on February 8th, during a severe streptococcus outbreak, was accompanied by a precipitous contraseasonal decline in streptococcic infections, and was followed by a striking drop in the incidence of rheumatic fever." Again "the only liability incurred . . . was the development of a few severe drug reactions." Dr. Coburn summarizes as follows: The Navy is working on a long-term program for the control of streptococcic infections and their sequelæ, dependent upon the mass administration of sulfadiazine as a prophylactic, but the present report deals with thirty thousand troops only. The conclusion reached is that one gram of sulfadiazine given daily will check a well advanced streptococcus epidemic. It will check the incidence, and will also protect some eighty-five percent of all susceptible recruits. It is almost eighty-five percent effective against implantation of streptococcus hemolyticus in the respiratory tract. Drug rashes are mentioned, and "dangerous constitutional disturbances in 0.01 percent! Finally, the Commander says: "Mass sulfadiazine prophylaxis is effective in checking bacterial infections of the respiratory tract, in preventing the development of disabling sequelæ caused by these bacteria, and in aiding the economy of a nation at war."

The contents of these two remarkable papers should be digested and held firmly in the memory of every practicing physician. One should suspect the streptococcus in every sore throat, should take cultures therefrom, and should administer sulfadiazine. Moreover, careful records, both clinical and laboratory, should be made in every case. A sharp watch should be kept on the heart and joints of every patient with a respiratory infection.

The Use and Abuse of Opium

It may be said that opium is, on the whole, the most valuable drug we have; at any rate, it is the most widely used; on the other hand, its abuse is an international menace. Some say that its narcotic properties were unknown to the ancients. Louis Lewin, in his *Phantastica Narcotic and Stimulating Drugs, Their Use and Abuse,* takes a contrary view, suggesting that the anodyne properties may have been known four thousand years ago, as relics of the Stone Age, the epoch of the lake dwellers, are from time to time discovered. Not only seeds but capsules of poppies have been found in the Swiss lakes. Furthermore, an examination of these capsules leads one to think that they came, not from the primitive form of the poppy, but were obtained by cultivation.

Be that as it may, the use of opium in ancient times is to be found recorded in very old documents. The

drug of forgetfulness, nepenthe, mentioned by Homer in the *Odyssey*, was no doubt a preparation of opium, and it was so well known by him that it is no stretch of the imagination to infer that the effects of opium must date back to a much earlier age. Asia Minor is called the cradle of opium, whence the poppy reached Rome, Greece and other countries. Paracelsus, the iconoclast, was among the first of the great figures of medicine to use opium, and he used it with a lavish hand. He is believed to have carried opium in the pommel of his sword.

Dr. Thomas Dover, who discovered Alexander Selkirk on the island of Juan Fernandez, and whose name will live in medical lore as the inventor of the powder which bears his name, followed the example of his erstwhile master, Dr: Thomas Sydenham, and gave heroic doses of the soporific drug. In old Greece and Rome, the seductive power of opium was well known and it had its votaries or victims by the thousands. The eating of opium increased *pari passu* with the wider knowledge of its beneficial properties, until its abuse has spread the world over.

Many great men have been its victims, de Quincey, Coleridge, Francis Thompson, Verlaine, Baudelaire, among them. The consumption of opium and its chief derivative, morphine, is immense at the present time. Indeed it may be called appalling, since the larger proportion is employed for illegitimate purposes.

News Items

Linsly R. Williams Memorial Lecture.—Dr. Iago Galdston delivered the Linsly R. Williams Memorial Lecture at the New York Academy of Medicine on Thursday evening, November 9th, his subject being "Psychiatry in the History of Medicine". This was the first in the tenth series of lectures to the laity.

Suiter Lecture.—Dr. Stuart Mudd, professor of bacteriology, University of Pennsylvania School of Medicine, Philadelphia, delivered the first A. Walter Suiter lecture on November 2nd, his subject being the rationale and means of disinfection of air. These lectures, created under the will of the late Dr. A. Walter Suiter, Herkimer, N.Y., will be conducted annually under the auspices of the Committee of Public Health Relations of the New York Academy of Medicine.

Symposium on Psychic Rehabilitation.—The nineteenth season of scientific sessions of the International Spanish Speaking Association of Physicians will be inaugurated on Friday evening, November 24th. The program will consist of a symposium on postwar rehabilitation of veterans and civilians suffering from psychic disorders. Dr. J. M. Gershberg, president of the association, returned recently from a trip to the West and South, and reports that he succeeded in establishing ten new chapters, with a membership of one hundred and sixty-two.

Friday Afternoon Lectures at the Academy.—Lectures in this series will be given during December as follows: December 1st: The problem of infection in burns, by Frank L. Meleney, College of Physicians and Surgeons, Columbia University; December 8th: Diagnostic observations on abdominal diseases, by Emanuel Libman, Mount Sinai Hospital; December 15th; The surgical treatment and course of essential hypertension, by Arthur M. Fishberg, Mount Sinai Hospital.

Nobel Prizes in Medicine.—It has been announced that the 1944 award of Nobel prizes in medicine has been made to four scientists, three of them Americans, and one a Dane. The 1944 award for work in both physiology and medicine went to Dr. Joseph Erlanger, professor of physiology of Washington University, St. Louis, and Dr. Herbert Spencer Gasser, of New York, director of the Rockefeller Institute, for their studies of the different functions of the individual nerve threads. The 1943 award, made after a year's delay, was shared by Dr. Edward A. Doisy, professor of biochemistry, St. Louis University School of Medicine, and Dr. Henrik Dam, Copenhagen, now at Strong Memorial Hospital, Rochester, N.Y. The prize was awarded for the discovery of the chemical nature of the K vitamin.

Urology Award.—The American Urological Association offers an annual award "not to exceed $500" for an essay (or essays) on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors are limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the Secretary, for full particulars. The selected essay (or essays) will appear on the program of the next annual meeting of the American Urological Association. Essays must be in the hands of the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 15, 1945.

American Public Health Association.—At the seventy-third annual meeting of this association, held in New York on October 4th, Dr. Milton J. Rosenau, Chapel Hill, N.C., was chosen president-elect, and Dr. John J. Sippy, Stockton, Calif., was installed as president, succeeding Dr. Felix J. Underwood, Jackson, Miss. Other officers were elected as follows: vice-presidents, Dr. Malcolm R. Bow, Edmonton, Canada; Carlos E. Paz-Soldan, Lima, Peru, and Marion W. Sheahan, R.N., Albany, N.Y. Dr. Reginald M. Atwater and Dr. Louis I. Dublin, New York, were reelected executive secretary and treasurer, respectively.

McGill Chinese Medical Fellowship.—Dr. Yang Gia-liang, associate professor of surgery, West China Union University, Chengtu, has been awarded the first fellowship under a recently inaugurated program of postgraduate training for Chinese physicians at McGill University Faculty of Medicine, Montreal, according to an announcement in the *J.A.M.A.* The fellowships will be known as the McGill-Chinese Medical Fellowships, "In token of appreciation of the heroism of the people of China, and particularly of the magnificent work done during the past ten years of the medical profession in that country."

Institute on the Exceptional Child.—The eleventh Institute on the Exceptional Child, held in Cleveland on October 24, 1944, under auspices of the child research clinic of the Woods Schools, presented a review of psychiatric progress as related to exceptional children. The speakers included, Dr. C. W. Wyckoff, Dr. Louis J. Karnosh, Dr. Wilmot F. Schneider, Dr. Henry C. Schumacher, Dr. E. Perry McCullagh, and Dr. Edward Zucker, all of Cleveland. A general discussion followed.

Pennsylvania Psychiatric Society.—The sixth annual meeting of this society was held in Pittsburgh, on September 21st under the presidency of Dr. Ralph L. Hill. The program included two addresses. James M. Henninger, Commander, M.C., U.S.N.R., Pittsburgh, spoke on "Navy Psychiatry, with particular reference to the South Pacific." Baldwin L. Keyes, Lieutenant Colonel, M.C., U.S.A., Philadelphia, spoke on "Psychiatry in the Middle East". The following officers were elected: president, Dr. George W. Smeltz, Pittsburgh; president-elect, Dr. Kenneth E. Appel, Philadelphia; secretary-treasurer, Dr. LeRoy M. A. Maeder, Philadelphia.

Drug Exhibit at the Academy.—Thirty-eight of the leading pharmaceutical companies of the United States are collaborating with an Academy committee on drug exhibits, of which Dr. Walter A. Bastedo is chairman, in an exhibit of drugs and other pharmaceuticals currently employed in combating infectious diseases. This exhibit was opened to the public October 9th, synchronously with the Seventeenth Graduate Fortnight of the Academy. This specific exhibit will be continued for the benefit of fellows of the academy and all physicians who visit the academy. From time to time the committee will replace the present exhibit by a new one illustrating the latest developments in the pharmaceutical world.

Symposium on Injuries of the Nervous System.—At a combined meeting of the New York Neurological Society and the Section of Neurology and Psychiatry of the New York Academy of Medicine, held on Tuesday evening, November 14th, a symposium was presented on injuries of the nervous system. The following papers were presented: "Surgical Considerations of Peripheral Nerve Injuries", by Dr. Byron Stookey, New York; "Management of Cranial Cerebral War Injuries", by Dr. Loyal Davis, Chicago; and "Some Psychiatric Aspects of Nervous System Injuries" by Lieut. Col. Walter Klingman, M.C., A.U.S. Dr. Foster Kennedy opened the discussion and Dr. Joseph E. J. King and Jefferson Browder took part.

Graduate Medical School to Include Dentistry.—According to an announcement in the *J.A.M.A.*, the Graduate School of Medicine of the University of Pennsylvania, organized in 1916 to provide for graduate studies in clinical medicine, will in the future extend its activities to include graduate studies in dentistry. The new work will be under the direction of John W. Ross, D.D.S., who has been appointed vice-dean for dentistry in the Graduate School and who will work in cooperation with the vice-deans for other medical studies under Dr. Robin C. Buerki, dean of the Graduate School of Medicine. In connection with the new graduate program in dentistry, courses are being planned for graduate studies in oral surgery, orthodontics, prosthetics and oral medicine-periodontics.

Anniversary of the American Society for the Hard of Hearing.—In commemoration of the twenty-fifth anniversary of the American Society for the Hard of Hearing, a combined meeting of the Section of Otolaryngology of the Academy of Medicine and the American Society for the Hard of Hearing was held on Friday evening, November 10th. The program was devoted to a consideration of the prevention and alleviation of the disorders and diseases associated with deafness, and papers were presented by Dr. Edmund P. Fowler, New York; Dr. Douglas Macfarlan, Philadelphia; Dr. Gordon Berry, Worcester, Mass.; Major Leslie E. Morrissett, office of the Surgeon General; Dr. Foster Kennedy, New York; and Dr. Iago Galdston, New York. A general discussion followed, and Mr. Howard Carter demonstrated various hearing aids.

Radiologists in the Army.—Speaking before the joint meeting of the American Roentgen Ray Society and the Radiological Society of North America, which met in Chicago last September, Colonel B. R. Kirklin, MC, senior consultant in radiology, Office of the Surgeon General, said that the Army Medical Department had overcome a serious shortage of competent radiologists at the beginning of the war by the intensive training of picked medical officers. At present, he said, there were approximately four hundred and fifty radiologists in the army who had been certified by the American Board of Radiology and about seven hundred and fifty more who had had training in radiology. Colonel Kirklin predicted that many of this latter group would continue their training after the war and become certified radiologists, bringing to their civilian work invaluable practical experience in connection with military injuries and diseases which are encountered chiefly in foreign lands.

Personal.—Dr. Ernest W. Goodpasture, professor of pathology, Vanderbilt School of Medicine, was awarded the Sedgwick Memorial Medal at the annual meeting of the American Public Health Association, held in New York in October. He is the fourteenth winner of the medal, "for distinguished service in public health."

Dr. J. C. Geiger, director of public health of the City and County of San Francisco, has been decorated by the president of Peru with the Order of the Sun of Peru for aiding materially in fostering and cementing friendly relations between countries of the Americas, and for his work in the prevention of disease.

First Lieutenant Ralph H. Major, Jr., M.C., of Kansas City, Missouri, aide de camp to General Hume in Italy, has been awarded the Cross of War for Military Valor by the Italian government.

Captain Weldon T. Ross, M.C., of McMinnville, Oregon, has been awarded the Legion of Merit in the European theater of operations, for "exceptionally meritorious conduct in the performance of outstanding services."

Lieut. Colonel Garfield George Duncan, M.C., has been awarded the Legion of Merit for his outstanding experimental work on the suppressive treatment of malaria in the Southwest Pacific area.

General Georges Andre Hugonot, Medical Corps, French Army, was cited on July 21st by the Commanding General of the Fifth Army, U.S. He is serving as Corps Surgeon of the French Expeditionary Corps on the Italian front.

Lasker Award for Mental Hygiene.—Dr. George S. Stevenson, medical director of the National Committee for Mental Hygiene, announces that the Albert and Mary Lasker Foundation, Inc., has established the Lasker award of $1,000 to be given annually through the committee for outstanding service in the field of mental hygiene. The purpose of the award is to recognize significant contributions to promoting mental health and to making the broad field and program of mental hygiene more familiar to the general public. The award this year will be for mental hygiene work related to the war. The recipient will be chosen from among leaders who have done work in the general enhancement of the mental health of the men and women of the services, both while in service and during the period of rehabilitation, so far as developed at the time. The activities for which the award will be made include psychiatric education, psychiatric organization and administration, psychiatric research, and psychosomatic medicine.

Army Ration Test.—The results of the controlled ration test using United States military personnel were highly satisfactory. Major William Beane, M.C., of Fort Knox, Ky., directed the test in cooperation with Major James Robinson, Infantry, and Captain David Bell, of the Royal Canadian Medical Corps. American and Canadian expeditionary rations were used. A battalion of American soldiers on maneuvers at an altitude of 8850 feet above sea level in Colorado were fed exclusively on American rations C, K, ten in one, and Canadian Mess Tin B ration for a period of sixty days. During this time they were engaged in vigorous combat training. At the conclusion of the test it was found that the troops were in better physicial condition than at the start, with high morale. The rations were proven to be wholly adequate to sustain troops in vigorous combat. Certain items in the rations, however, were found to be less acceptable to the men than others, and these will be improved. Four consultants in nutrition to the Surgeon General, Dr. Julian M. Ruffin, Dr. Frederick J. Stare, Dr. R. H. Kampmeier, and Dr. Virgil P. Sydenstricker assisted in the physical examinations, and Dr. Albert Mendeloff and Dr. Carleton B. Chapmen of the Public Health Service aided in the test. A unit from the Harvard Fatigue Laboratory under Dr. R. E. Johnson performed the laboratory examinations.

Symposium on Premedical Education.—Alpha Epsilon Delta, national honorary premedical fraternity, sponsored a symposium on premedical education at the Cleveland meeting of the Association for the Advancement of Science in September, 1944. More than seventy teachers and administrators from various colleges throughout the country attended. Dr. H. E. Setterfield, national president of Alpha Epsilon Delta, opened the symposium and Dr. Victor Johnson, secretary of the Council on Medical Education and Hospitals of the American Medical Association, presented a paper on "Objectives in Premedical Education" from the medical point of view. An interesting discussion which followed showed a realization of the many important problems involved in premedical training. Plans for further investigation of these problems were proposed by Dr. Setterfield. The remarks and suggestions submitted will be published in pamphlet form. Copies may be had upon request to Dr. Maurice L. Moore, 3853 Lakewood, Detroit 15, Michigan.

Book Reviews

Heart Disease

Heart Disease. By Paul White, M.D., lecturer in medicine, Harvard Medical School, etc. Third edition, completely revised and reset. New York: The Macmillan Company, 1944. Pp. 1025. Price $9.00.

This scholarly monograph on heart disease is a systematic survey embodying recent advances. Yet, most of the unanswered questions asked in the first edition remain today without adequate reply. An important addition is a chapter on the range of the normal heart, phonocardiography, precordial leads, ligation of the patent ductus arteriosus, modern treatment of subacute bacterial endocarditis, splanchnic resection, management of intracardiac thrombosis, pulmonary embolism and vascular accidents throughout the body. In addition, there are more historical references giving the evolution of each disease entity. There are also illustrations to emphasize new facts on the mechanism and management of heart disease. This edition marks the finest contribution to clinical cardiology now available in any language.

Neurosyphilis

The Management of Neurosyphilis. By Bernhard Dattner, M.D., associate clinical professor of neurology, New York University College of Medicine. With the collaboration of Evan W. Thomas, M.D. and Gertrude Wexler, M.D. Foreword by Joseph Earle Moore, M.D., associate professor of medicine, Johns Hopkins University. New York: Grune and Stratton, 1944. Pp. 398. Price $5.50.

Some ten years ago (1933) Dattner, then an assistant in the Vienna Clinic of Wagner-Jauregg, published a monograph on neurosyphilis which did not reach the eyes of most American physicians who would have been interested. Five years later the author escaped to this country and began to work at Bellevue with Dr. Thomas and Dr. Wexler. Together they have contributed much useful clinical material, especially concerning the changes in the spinal fluid in neurosyphilis. The importance of diagnosis by means of this fluid is manifest since one may have a negative blood Wassermann and a positive spinal.

Part I deals with the technique of withdrawal, examination, interpretation, and evaluation of spinal fluid and its "syndromes". No doubt diagnosis is often made later than it should have been, since the symptoms in brain and cord are often those of some ordinary indisposition which may be called hysteria, nervous exhaustion, indigestion, or even awkwardness and clumsiness. It was Delafield who proclaimed that when in doubt about the cause of an obscure condition it was always well to "smell syphilis". Headache, for example, means little to many of us, but headache coming on at night should cast suspicion on cerebral syphilis. As common as the spirochete is, we still may overlook its ravages until a diagnosis is self-evident.

Part II deals with methods of treatment, application and results. Dattner did his work, apparently, without benefit of penicillin. If present enthusiasm holds out, this new agent may revolutionize the treatment of syphilis in the early stages. Advanced syphilis will probably always be recalcitrant because of the vast structural changes which have taken place. Our chief reliance now in terminal syphilis is on "fever therapy".

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NOVEMBER 1944

Medicolegal Notes

Unusual Workmen's Compensation Case

A workman, in hospital for treatment of an injury sustained in the course of his employment, was warned not to smoke because the bandages on his injured hand were kept wet with alcohol. Disregarding the warning, he lit a match, the alcohol ignited, resulting in further injury, burns so severe as to require amputation of three fingers and a thumb, his index finger having been amputated after the compensable injury. It was held that the injury due to the burning did not arise out of the employment and the Compensation Bureau's judgment holding it not compensable was sustained. McDonough vs. Sears, Roebuck and Co., New Jersey Court of Errors and Appeals, 33 A. 2d 861, affirming 127 N. J. L. 158, 21 A. 2d 314.

Accidental Means

In an action on a life policy providing for payments for injuries sustained through accidental means, the Texas Court of Civil Appeals holds, American Casualty and Life Co. vs. McCracken, 173 S. W. 2d 212, that evidence showing that the plaintiff physician was driving to his home, along a highway which intersected a railroad, at about twenty miles an hour, that he knew there was a railway somewhere in the general vicinity but did not know exactly where it was; that as he came around a curve he either ran into or was struck by a black engine which was undistinguishable in the darkness; that no warning was given by the operator of the engine that it was either on or approaching the intersection, sustained the trial court's conclusion that the injuries were caused by accidental means, because, although the insured intended to do everything he did, he did not know and had no warning of the presence of the engine; the happening was unforeseen, unexpected and unusual.

Taking Poison by Mistake Excluded by Accident Policy

The Georgia Court of Appeals, Liberty National Life Insurance Co., vs. Kirk, 11 S. E. 2d 716, holds that the death of an insured caused by the taking of poison, as the result of a mistake, falls within an exception in an insurance policy that the insurer will not be liable to pay the extra benefit or double indemnity therein provided for "if the insured's death . . . is caused by taking any kind of poison . . . whether voluntarily or otherwise". It has been held that death resulting from the taking of poison by mistake is within the terms of a policy insuring against death by external, violent and accidental means. But the exception quoted, the court holds, "clearly means that the company is not liable under the policy to pay the extra or additional benefit therein provided for accidental death when such death was caused by the taking by the insured of any kind of poison, whether such poison was taken intentionally or through accident or mistake, and would include the voluntary taking of a supposedly harmless drug which, through a mistake and accident on the part of the druggist, was in reality a deadly poisonous drug".

Acceleration of Buerger's Disease

A longshoreman claimant recovered a judgment under the Longshoreman's act for total disability resulting from aggravation of a preexisting disease—Buerger's disease—even though the same disease would have totally disabled the plaintiff without any accident at all. A medical witness testified that the injury (by a crowbar striking his left foot) had accelerated the "manifestations" of the arterial disease by about two years. Buerger's disease is progressive. The connection between the accident and the disease was not broken by the fact that the longshoreman, having this disease, would have eventually arrived at his present state of disability even though there had been no accident. The District Court therefore properly set aside an order terminating the plaintiff's compensation and reinstated his compensation payments. Bernatowicz vs. Nacirema Operating Co., Inc. Third Circuit Court of Appeals, 742 F. 2d 385.

Reciprocity Statute

Under the Michigan statute permitting the State Board of Registration in Medicine to grant a certificate of registration to an applicant registered in another state which has registration requirements similar to those of Michigan, the Michigan Supreme Court holds, Solowitz vs. State Board, 285 Mich. 214, 280 N.W. 737, that the acts of the board must be based upon the exercise of sound discretion; but broad discretionary powers must necessarily be granted, and it is only when that discretion is abused that the courts will interfere.

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(1) Am. J. Obst. & Gyn., 35:839, 1938. (2) West. J. Surg., Obst. & Gyn., 51:150, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec., 155:316, 1942.

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Sulfonamides in the Treatment of Tonsillitis

Captain Edward D. Freis, Medical Corps, A. U. S., discusses the value of small doses of sulfonamides in the treatment of tonsillitis (*J.A.M.A.* 126:2:93-94, Sept. 9, 1944). He says since it is generally acknowledged that tonsillitis is responsible for a significant number of the total man hours lost to industry and the armed forces, the advisability of treating acute follicular tonsillitis with sulfonamides has been the subject of a variety of studies. The use of large doses of sulfonamides in treating tonsillitis is still a controversial question. Some believe that since this disease is relatively benign and self-limited, chemotherapy is unnecessary and even dangerous, a view which is supported by the number of serious toxic reactions that have resulted from the indiscriminate use of the sulfonamides. Others believe that early treatment with sulfonamides appreciably shortens the course of the disease. In addition to systemic therapy, the local treatment with sulfonamide sprays has become popular. Effective therapeutic results and an absence of drug reactions have been reported following the use of local sprays in the treatment of various upper respiratory infections. In order to establish the relative efficacy of the local and systemic administrations of sulfonamides in the treatment of tonsillitis it was decided to study the question under controlled conditions, using hospitalized patients. The results showed that the groups which received sulfonamides, either locally or systemically, showed a return to normal temperature and clinical recovery in an appreciably shorter period of time than the controlled group treated with irrigations alone. The criteria for clinical recovery were complete relief of symptoms and disappearance of erythema, edema and follicles. No toxic reactions or evidences of sensitization developed in the patients who received sulfonamides. As a result of these studies the author concludes that the administration of small doses of sulfonamides appreciably shortens the course of acute follicular tonsillitis and minimizes the complication of peritonsillar abscess. Small doses of sulfadiazine administered by mouth in tablet form are as effective as the local application of sulfonamides to the tonsillar area in the form of a powder spray. The ease of administration makes the systemic route the ideal therapeutic procedure. There were no toxic or sensitization reactions observed in any of the patients.

Negro Health in the United States

Dr. E. I. Robinson, president of the National Medical Association, in testifying before the United States Senate Subcommittee on Wartime Health and Education, in Washington, D.C. on September 19th, said that health conditions among the Negro population of the United States presented a serious problem. He pointed out that the mortality rate among Negroes in the United States was approximately thirty to forty percent higher than among whites, and that the average expectancy of life among Negroes was ten to twelve years shorter than among whites. The tuberculosis mortality rate among Negroes in the United States was said to be three times as high as for whites, and even higher in certain cities and certain age groups. The indications were that venereal disease was a more acute problem among Negroes than among whites, and the maternal and infant mortality rates was about twice that of the

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crowds and coryza!

The Common Cold . . . it *mixes* with the crowds, and it *meddles* to an extent which has meant as many as 23,000,000 persons ill with colds during a single week.[1] A review of the "sick list" in American shops and offices reveals other startling figures on the anti-production menace of the common cold. For instance, a reliable survey[2] shows that, in one winter month, thousands of workers were affected, with a resulting loss of 1,600,000 man-days of labor. In summary: Three out of four are attacked in winter . . . one out of twenty, even in midsummer. Immunologic responses to the so-called cold virus are relatively transient. Prophylactic indications, therefore, are directed toward active immunization against bacteria associated with the more severe types of common cold.

'VACAGEN' ORAL COLD VACCINE TABLETS are designed to produce active immunity against ten, specific, pathogenic bacteria believed responsible for the more severe manifestations of colds, grippe, and similar acute infections of the upper respiratory tract.

Supplied in vials of 20, and in bottles of 100, 500 and 1000. **Sharp & Dohme, Philadelphia 1, Pa.**

1. Ending February 24, 1942. 2. November 24-December 20, 1941. American Institute of Public Opinion.

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CACODYNE special iodine and cacodylate furnish glandular nutritional sustenance for sustained cardiovascular relief in hypertension, angina pectoris and allied conditions. Minimized arterial occlusion, cellular exudate and cholesterol deposit improve coronary and general circulation. Hundreds have shown improvement upon administration of . . .

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Negro. He believed that medical care and medical health programs and services should be made available to this group of American citizens on the basis of need rather than considerations of population. There was also a great need for increased hospital facilities and health centers for Negroes. In the southern states especially, there were not enough physicians, nurses, and social workers to serve the Negro population.

Harrower Laboratory Affiliated With the Lambert Company

Mr. J. L. Johnston, president of The Lambert Company, announces the acquisition of The Harrower Laboratory, Inc., Glendale, California, producers of pharmaceutical specialties for the medical profession and specialists in the field of endocrinology since 1918. Dr. Henry R. Harrower will continue as consultant and director, Dr. R. B. Haining will remain as executive vice-president and general manager, and H. C. Nelson as secretary-treasurer.

No change will be made in the actual operation of The Harrower Laboratory. The home office and plant will remain in Glendale, with the same management and personnel, and strictly ethical policies will be followed as heretofore. Plans have been formulated for improvement and expansion of research and production departments.

E. H. Canright, general sales manager of The Harrower Laboratory, Inc., at the same time announces the promotion of B. F. Towne from Chicago District sales manager to assistant general sales manager in charge of sales and distribution in the Middle West and on the Eastern Seaboard.

On the Job—OUR FEMININE "MANPOWER"

OFFICIALS of the War Manpower Commission assert that women today can capably "take over" any man's job, *provided it is within their physical powers.*

Menstrual aberrations, however, cause frequent absenteeism and loss of efficiency. For the symptomatic treatment of functional conditions, physicians find Ergoapiol (Smith) a highly efficient emmenagogue, in which the action of all the alkaloids of ergot (prepared by hydro-alcoholic extraction) is synergetically enhanced by the presence of apiol, oil of savin, and aloin.

Its sustained tonic action on the uterus provides welcome relief in many cases—by helping to induce local hyperemia and to stimulate smooth, rhythmic uterine contractions, and by serving as a potent hemostatic agent to control excessive bleeding.

May we send you a copy of the booklet "The Symptomatic Treatment of Menstrual Irregularities."

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INDICATIONS

Amenorrhea, dysmenorrhea, menorrhagia, metrorrhagia, in obstetrics.

Dosage: 1-2 cap. 3-4 times daily.

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THE PREFERRED UTERINE TONIC

Ethical protective mark, M. H. S., visible only when capsule is cut in half at seam.

The Great *Incapacitator*

The common cold is responsible for more disability and loss of working time than any other disease.

Therefore, much has been written in the medical literature—both pro and con—concerning the value of oral catarrhal vaccines in preventing colds and their complications. The vast preponderance of evidence, based on controlled clinical studies, shows that oral vaccination *does* reduce illness and absenteeism resulting from colds.

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Brand of Oral Catarrhal Vaccine

REDUCES INCIDENCE, SEVERITY AND DURATION OF COLDS

Oravax is a small, white, enteric-coated tablet containing a wide range of antigens selected for their ability to build protection against organisms of secondary invasion responsible for debilitating sequelae of the common cold.

Convenient, painless, free from severe reactions, Oravax can be used alone or as follow-up to injections. Dosage is one tablet daily for 7 days, then one tablet twice weekly throughout season when colds are most prevalent.

At prescription pharmacies in bottles of 20, 50 and 100.

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Neuronidia's sleep-inducing action is not only prompt but usually assures adequate sleep from which the patient awakens refreshed.

When given in small doses during the day, Neuronidia has proved an excellent sedative in various neuroses.

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Army Surgeons Girdle the Globe

The Army Medical Department has thrown a network of surgery around the globe, so American soldiers on every front may receive prompt and continued skillful surgical care, said Brigadier General Fred W. Rankin, U.S. Army, in a recent interview. Closest to the line of battle and almost always under artillery fire, he continued, are the battalion aid stations where emergency surgery may be performed. Further behind the lines are the collecting stations which prepare the men for transportation, and the clearing stations which have complete surgical equipment.

When the nature of the battle warrants it, clearing stations are reinforced by the addition of mobile surgical units which move as close to the fighting line as possible. The equipment is carried on specially designed automobile trucks and when no farmhouse or other building is available, the hospital is set up in tents. These mobile surgical teams operate promptly on head, chest, abdomen and other emergency cases which cannot stand transportation.

Other wounded personnel are sent to the evacuation hospitals for pre-operative treatment and definitive surgery. If additional treatment is needed, the man is sent to a general hospital far removed from the combat zone. If he cannot be returned to duty within a limited time, he is sent to a general hospital in the United States.

General hospitals in this country now include twenty neurosurgical centers, five centers for chest surgery, six amputation centers, and five plastic surgery centers, as well as other hospitals devoted to special cases.

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High Potency B-Complex With Mineral Support

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Since patients are not mechanically minded, simplicity and ease of handling are prime requisites for continued use. Lanteen Flat Spring Diaphragm is extremely simple to place—it is collapsible in one plane only. No inserter required.

Effective Contraception Proved by Clinical Tests

• The *Lygel* contraceptive method (using patented applicator) was prescribed for several hundred patients of a well-known Birth Control Center. *Lygel Vaginal Jelly* proved effective, both with and without the Diaphragm . . . with no pregnancies reported over the 18-month test period.

Recently 5 accredited vaginal jellies were tested under strict laboratory control . . . In 3 sets of "mixing" tests, employing 1 part jelly with 2 or 3 parts saline and 50% semen, *Lygel Vaginal Jelly* was found to be completely efficient in spermicidal activity . . . In "contact" tests spermatozoa were immobilized *on contact*, even when diluted with an equal volume of saline.

The detailed reports of the tests mentioned are available to you on request.

Lygel Vaginal Jelly is non-irritating and non-injurious in continued use. It is available in slip-label packaging for ethical dispensing and is promoted through the medical profession.

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ards the Medical Department has traveling consultants in surgery, neurosurgery, and orthopedic surgery in each service command who visit the hospitals of that command regularly. These consultants, drawn from our leading medical schools and top-ranking surgical societies, represent the finest surgical talent in America.

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Hoffmann-La Roche, Inc., of Nutley, New Jersey, announces to the medical profession a new pleasant-tasting wafer for oral calcium therapy called Larocal Wafers with vitamins C and D. This is not "just another" oral calcium preparation. Larocal Wafers contain a generous amount of calcium in the form of calcium arabonate, a readily soluble, nonirritating, well tolerated, and promptly absorbed salt which is free from chalky taste. In addition, Larocal Wafers supply vitamins C and D in generous quantities—the latter for its important rôle in the absorption and utilization of calcium and the former for its part in the formation of dentine and bone matrix. These three ingredients—calcium arabonate, vitamin C and vitamin D—are incorporated into a candy-like wafer with a pleasant taste—a taste so agreeable that not even squeamish patients, young or old, need to be coaxed to take Larocal Wafers. Like all Roche products, Larocal Wafers will be marketed only through professional channels and will never be advertised to the laity. They are available in boxes of thirty and one hundred. A descriptive Larocal Wafers booklet will be furnished upon the request of the physician.

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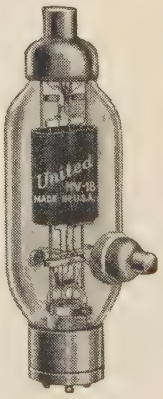

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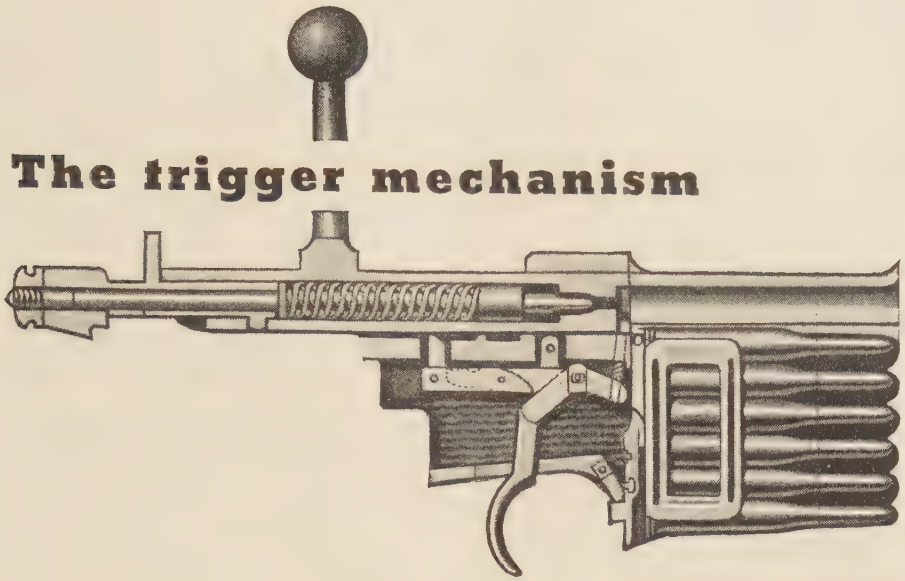
The trigger mechanism



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VENOUS ENGORGEMENT, the trigger mechanism of hemorrhoids, can be set off by simple constipation, by a bout of diarrhea, by pregnancy or by any one of many well known etiologic factors.

'Anusol'* hemorrhoidal suppositories exert an emollient, decongestive action either to suppress this trigger mechanism, or to afford relief from its resulting pain, discomfort and other sequelae. Yet 'Anusol' hemorrhoidal suppositories contain no substance which will mask more serious pathology or produce unwanted systemic effects. Each 'Anusol' hemorrhoidal suppository is composed of bismuth subgallate 2.25; bismuth oxyiodide 0.04; bismuth resorcin compound 1.75; Nicaraguan balsam (medicinal) 3.00; zinc oxide 11.00; acid boric 18.00, in a base of purest cacao butter, benzoinated lard and beeswax, q. s. ad. 100.00. Boxes of 6 and 12 suppositories.

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Natural vitamin A in a complete supportative vitamin and mineral base. Daily ration provides following proportions adult daily requirements:

A—250%	10,000 Int. Units
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Plus additional natural factors and all minerals concentrated from sixteen fresh vegetables.

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Puerto Rico's Proposed Medical School

It is announced in the *J.A.M.A.* that a six hundred bed hospital and ten other buildings to be spread over thirty acres of land are included in the general plans for the proposed medical school in Puerto Rico to be established under the auspices of the University of Puerto Rico, San Juan, with an allotment of $500,000 granted by local law to organize the school. The complete cost of the project will ultimately be $4,500,000. It is planned to have a contagious disease hospital in a four story building providing one hundred beds; a cancer hospital of the same size, already approved by the Insular Health Department; an ophthalmic institute of the same size; a service building with an electric plant, laundry and other services; a blood bank and other laboratories; a kennel for animals used in experiments; a pharmacy and dentistry school; class room units; a dormitory for nurses; a dormitory and cafeteria for two hundred students; a psychiatric hospital, and a school for obstetrics. There would also be recreation facilities. The school would graduate fifty doctors each year.

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NOW more than ever!

Periodic physiologic "let-down" in women is likely to be more pronounced during these days of added stress and strain unless effective therapy is instituted.

HYPEROL

provides a balanced formula of established value for symptomatic control of certain functional utero-ovarian irregularities. HYPEROL acts to relieve pain, reduce congestion, and to improve general well being through hematinic benefits .... so that normal activities may be pursued.

HYPEROL

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contains Hydrastine Alkaloid, Aloin, Apiol, and Ferrous Carbonate (Blaud).

Samples to Physicians Upon Request.

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BEFORE TREATMENT

Inferior and middle turbinates are highly engorged and in contact with the septum. The airway is completely blocked.

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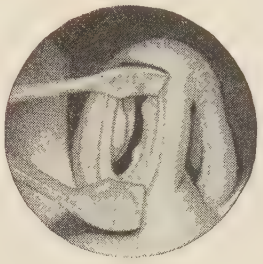
Maximum shrinkage has been obtained with 2 inhalations from Benzedrine Inhaler. The turbinates are contracted. The airway is open.



Butler and Ivy state that—for administering vasoconstrictive drugs—inhalers and sprays are preferable to nasal drops, and are—in most cases—"the better means of nasal medication," because: (1) ". . . the drug reaches the nasal mucosa in more diffuse form . . ."; (2) " . . . the mucosa is never severely ischemic at any one point, but the effect is spread throughout the nasal cavity . . ."; (3) even when prolonged medication is required, there is ". . . far less pathologic change than that resulting from the use of nasal drops."

Arch. Otolaryng., 39:109-123, 1944.

Each Benzedrine Inhaler is packed with racemic amphetamine, S. K. F., 200 mg.; oil of lavender, 60 mg.; and menthol, 10 mg.

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Written with Confidence!

The physician who prescribes Mandelamine in the treatment of urinary infections may rest assured that it will promote prompt and effective relief without danger of toxicity and irritation which are common occurrences when certain other urinary antiseptics are employed.

This freedom from by-effects makes Mandelamine of eminent value in the treatment of obstinate cases in which the medication must be continued for long periods of time. For the same reason, Mandelamine therapy is indicated when dealing with urinary infections in children, and during pregnancy.

Of definite advantage to the busy physician is the convenience of administration which Mandelamine offers through elimination of the need for routine urinary pH control, accessory acidification, adjustment of fluid intake, and dietary regulation.

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Supplied in enteric coated tablets of 0.25 Gm. each, sanitaped, in packages of 120, 500 and 1000.

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Rural Hospitalization

Dr. John Radford Boling, president of the Florida Medical Association, testifying before the United States Senate Subcommittee on Wartime Health and Education, Washington, D.C., September 20th, said that the government was in a position to make a constructive contribution to the solution of the problem of rural hospitalization. By supplying funds for a conservative building program it could provide general hospitals in those areas in which it is shown by the state and county health departments, working in close conjunction with the state and county medical societies, that the need actually exists. Funds for such projects might well be supplied jointly by the federal government and the state through the state Public Health department. These hospitals should not be large, nor too extensively or elaborately equipped and staffed, for they should become feeders for the nearest medical centers in so far as possible. It is to be stressed that the communities served by these hospitals would not have sufficient population to support a staff of specialists. Aside from the economic aspect, there would not be enough work to keep the specialist proficient in his chosen field.

A period of military training, or some sort of special training contributory to it, for all within specified age limits will doubtless be a feature of the immediate postwar years. Rural hospitals might well be staffed with physicians who have completed an internship of at least one year and who are permitted by a residency in a rural hospital to meet the requirement for compulsory service. In addition to their regular duties in this capacity, they could aid in caring for the indigent during their tenure of service by becoming members of the local county health department.

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1 MILDLY SEDATIVE

GLYKERON
ALCOHOL 3½ PER CENT
EACH FLUID OUNCE CONTAINS 1 GRAIN CODEINE PHOSPHATE (OPIUM DERIVATIVE)
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4 FLUID OUNCES

2 STRONGLY EXPECTORANT

• It aids in breaking the vicious circle of coughs that are uselessly irritating or unproductive.

Dosage: For adults 1–2 teaspoonfuls every 2–3 hours or longer; children in proportion.

Supplied: In 4 oz., 16 oz., and half-gallon bottles.

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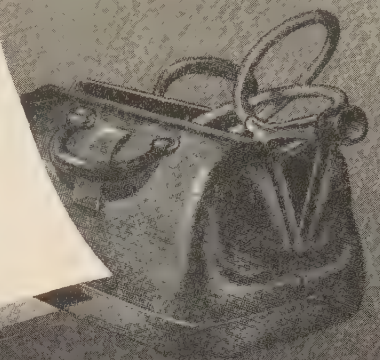
AN IMPORTANT MESSAGE TO PHYSICIANS who prescribe B complex

Within the Stuart Formula multivitamin concentrate is contained in addition to vitamins A, D, C, E and minerals—a complete B complex with natural B complex factors from liver extract, yeast extract and high potency yeast.



TAKE a look at *any* of the B complex products you may now be prescribing and compare them with the Stuart Formula for unitage and price. You will find that your patients will get, in addition to vitamins A, D, C, E and iron, manganese and iodine, a greater B complex unitage at a lower cost in the Stuart Formula than in products containing B complex alone. For that matter, compare the Stuart Formula with *any* ethical multivitamin product for potency, balance and cost.

Two tablets (daily dose) standardized to contain:

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B_1 (thiamin chloride)	3.75 milligrams (1,250 USP units)
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PP (niacin and niacin amide)	25 milligrams (25,000 micrograms)
B_6 (pyridoxin)	200 micrograms
Calcium Pantothenate	500 micrograms

ALSO other members of the B complex from natural sources—*high potency yeast, grain concentrate, yeast extract and liver extract —including Biotin* (1.5 *micrograms*), *Folic Acid* (2.5 *micrograms*).

OTHER VITAMINS IN STUART FORMULA

A (fish liver oil, purified esters)	5,000 USP units
D (activated ergosterol)	800 USP units
C (ascorbic acid)	75 milligrams (1,500 USP units)
E (natural tocopherol)	1 milligram
PLUS MINERALS	
Iron (ferrous sulphate)	15 milligrams
Manganese (manganese sulphate)	7.5 milligrams
Iodine (potassium iodide)	0.15 milligram

NOTE: The Stuart Formula either meets or exceeds all potency requirements for all vitamins as recommended by THE NATIONAL RESEARCH COUNCIL . . . including Natural B complex factors and minerals.

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Seeing Ability of Animals

Ability to see well under different conditions of illumination regulates to a large degree the habits and activities of animals, says the Better Vision Institute. The Institute finds that there are five broad classifications of animals, based upon the characteristics of their eyes. These are:

First, animals whose eyes are suitable chiefly for seeing in the bright light of day. They cannot see well in light dimmer than moonlight, and hide and are inactive at night.

Second, the animals with nocturnal eyes. Such beasts have eyes that are extremely sensitive to dim light. They roam about at night, and sleep or bask in the sun quietly in the day. Often their eyes have mechanisms for reducing the bright light of day.

Third, animals whose eyes are adapted for seeing at medium light intensities. These creatures carry on their daily activities during the hours of dawn and twilight, resting or sleeping in the brightness of day or the darkness of night.

The fourth group includes those animals with eyes highly sensitive to light and lacking eye mechanisms to stop down the amount of light entering the eyes. These beasts are active only in the depth of darkness. Unlike the nocturnal-eyed creatures, they do not bask in the sun. They secrete themselves and sleep in a dark place during the day.

The fifth class includes those with twenty-four-hour eyes—eyes that can see around the clock by adapting themselves to varying light intensities. Such animals are active day and night, catching a nap now and then.

FOR IODINE RESULTS WITHOUT THE USUAL IODINE DISTURBANCES

ORGANIDIN—WAMPOLE

A STABLE PREPARATION OF IODINE

IODINE

ORGANICALLY COMBINED

FOR INTERNAL ADMINISTRATION

Freely miscible with water. Contains no free iodine, no hydriodic acid, no inorganic iodides and no alcohol.

ORGANIDIN is absorbed readily from the gastro-intestinal tract, with less irritation and less toxicity than is produced by elementary iodine. Thus it permits a maximum effect with a minimum iodine dose.

A superior product which may be administered over an extended period of time with little probability of causing gastro-intestinal disturbances or iodism.

SUPPLIED IN 1-OZ. BOTTLES

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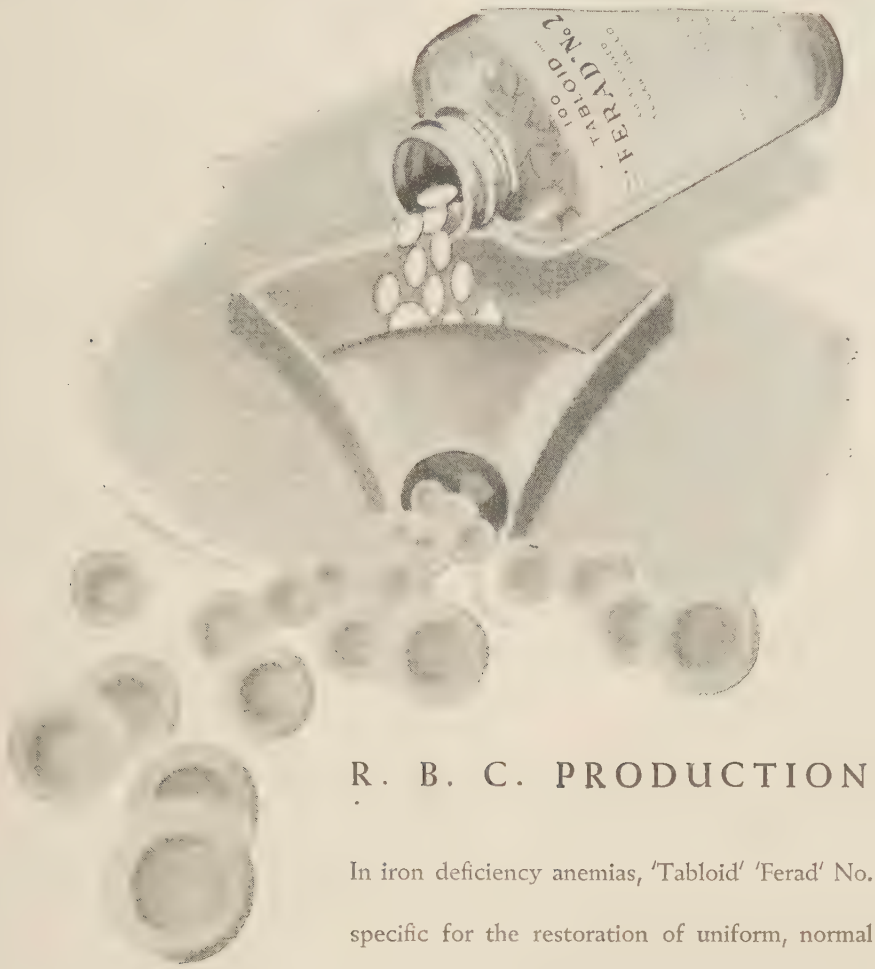

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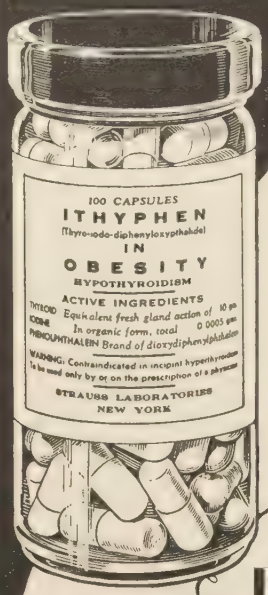

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